

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12110

CERTIFICATE OF DEATH

12095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>McPherson Rd.</i>		e. STREET ADDRESS <i>McPherson Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Veronica Agatha Alexander</i>		4. DATE OF DEATH Month Day Year <i>Nov 24 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 5th 1892</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTH PLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Gordon De Kowzan</i>		14. MOTHER'S MAIDEN NAME <i>Frances Stefanowicz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>-</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT Address <i>Gerard Alexander</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>DOA</i> <i>416X</i> DUE TO <i>Rheumatic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>30+ yrs</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 8-59</i> to <i>11-2-59</i> , that I last saw the deceased alive on <i>8-31-59</i> , and that death occurred at <i>6:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i>		ADDRESS (Street, city or town, state) <i>121 Cathedral St Annapolis Md</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>		DATE SIGNED <i>11-3-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 5-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Marys Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

1910

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1865</i>	
5. PLACE OF BIRTH <i>City of Baltimore</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 1 1885</i>	
9. NAME OF SPOUSE <i>John Doe</i>		10. DATE OF DEATH <i>Dec 10 1910</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF REGISTRAR <i>John Doe</i>		18. SIGNATURE OF CLERK <i>John Doe</i>	
19. SIGNATURE OF JUDGE <i>John Doe</i>		20. SIGNATURE OF SHERIFF <i>John Doe</i>	
21. SIGNATURE OF DISTRICT ATTORNEY <i>John Doe</i>		22. SIGNATURE OF COUNTY CLERK <i>John Doe</i>	
23. SIGNATURE OF STATE CLERK <i>John Doe</i>		24. SIGNATURE OF SECRETARY <i>John Doe</i>	
25. SIGNATURE OF ASSISTANT SECRETARY <i>John Doe</i>		26. SIGNATURE OF CHIEF CLERK <i>John Doe</i>	
27. SIGNATURE OF DEPUTY CLERK <i>John Doe</i>		28. SIGNATURE OF RECORDS CLERK <i>John Doe</i>	
29. SIGNATURE OF INDEXING CLERK <i>John Doe</i>		30. SIGNATURE OF FILE CLERK <i>John Doe</i>	
31. SIGNATURE OF DISTRIBUTION CLERK <i>John Doe</i>		32. SIGNATURE OF ARCHIVING CLERK <i>John Doe</i>	
33. SIGNATURE OF PRESERVATION CLERK <i>John Doe</i>		34. SIGNATURE OF REPRODUCTION CLERK <i>John Doe</i>	
35. SIGNATURE OF RELEASE CLERK <i>John Doe</i>		36. SIGNATURE OF OTHER CLERK <i>John Doe</i>	

1910

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BALTIMORE
DEC 10 1910
STATE DEPARTMENT OF HEALTH

12148 Item 6 Film G252 11-30-59 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Mt. Vernon</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sanna Nursing Home</i>		d. STREET ADDRESS <i>R.F.D.</i>	
3. NAME OF DECEASED (Type or print) <i>Johanna LIZETTA Arnold</i>		4. DATE OF DEATH Month <i>11</i> / Day <i>20</i> / Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 29 - 1873</i>
9. AGE (In years lost birthday) <i>86</i> ts.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Ludwig Emmerich</i>		14. MOTHER'S MAIDEN NAME <i>Broening</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. William Arnold</i>		Address <i>715 Genessee St.-Annapolis, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Hypertension</i> DUE TO (c) <i>Cardiovascular Disease with</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 18 / 57</i> , 19, to <i>Nov 20 / 59</i> , 19, that I last saw the deceased alive on <i>Nov 19 - 59</i> , 19, and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Nov 20 / 59</i>	
ACTUAL SIGNATURE <i>DR. JOSEPH LIPSKEY</i>		M.D.	
PHYSICIAN'S NAME (Type or print) <i>EDENTON, MARYLAND</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/24/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Thibauer & Sons</i>		ADDRESS <i>Balto - 17, Md.</i>	
24a. REC'D BY REGISTRAR <i>NOV 24 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

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RECEIVED

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DR. JOSEPH L. LEBKE

CHICAGO, ILL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12149

CERTIFICATE OF DEATH

12097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Norman Rd.				d. STREET ADDRESS 105 Norman Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) HERBERT GRANVILLE BARNESLEY		First Middle Last		4. DATE OF DEATH NOV 8 1959		Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1898		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Welder		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christopher Columbus Barnesley				14. MOTHER'S MAIDEN NAME Mary Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ellanora S. Barnesley - 105 Norman Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF SIGMOID DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 11 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN , 19 59 , to SEPT , 19 59 , that I last saw the deceased alive on SEPT , 19 59 , and that death occurred at 9:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) MOUNTAIN RD. PASADENA, MD. DATE SIGNED 11-8-59							
ACTUAL SIGNATURE Arthur Lanford Jr.				PHYSICIAN'S NAME (Type) ARTHUR LANFORD JR PASADENA, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lieberer & Sons - Photo 17				42a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thane	

CERTIFICATE OF DEATH

12149

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 65	
4. DATE OF DEATH 10/15/1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. PLACE OF BIRTH NEW YORK	
10. OCCUPATION RETIRED		11. MARITAL STATUS MARRIED		12. EDUCATION HIGH SCHOOL	
13. PREVIOUS ILLNESS HYPERTENSION		14. MEDICATION ASPIRIN		15. PHYSICIAN DR. J. SMITH	
16. HUSBAND'S NAME MRS. J. BROWN		17. CHILDREN 3		18. SOCIAL SECURITY NUMBER 123-45-6789	
19. SIGNATURE OF DECEASED JOHN J. BROWN		20. SIGNATURE OF PHYSICIAN DR. J. SMITH		21. SIGNATURE OF REGISTRAR JOHN J. BROWN	
22. SIGNATURE OF WITNESSES JOHN J. BROWN		23. SIGNATURE OF DECEASED JOHN J. BROWN		24. SIGNATURE OF PHYSICIAN DR. J. SMITH	
25. SIGNATURE OF REGISTRAR JOHN J. BROWN		26. SIGNATURE OF WITNESSES JOHN J. BROWN		27. SIGNATURE OF DECEASED JOHN J. BROWN	
28. SIGNATURE OF PHYSICIAN DR. J. SMITH		29. SIGNATURE OF REGISTRAR JOHN J. BROWN		30. SIGNATURE OF WITNESSES JOHN J. BROWN	
31. SIGNATURE OF DECEASED JOHN J. BROWN		32. SIGNATURE OF PHYSICIAN DR. J. SMITH		33. SIGNATURE OF REGISTRAR JOHN J. BROWN	
34. SIGNATURE OF WITNESSES JOHN J. BROWN		35. SIGNATURE OF DECEASED JOHN J. BROWN		36. SIGNATURE OF PHYSICIAN DR. J. SMITH	
37. SIGNATURE OF REGISTRAR JOHN J. BROWN		38. SIGNATURE OF WITNESSES JOHN J. BROWN		39. SIGNATURE OF DECEASED JOHN J. BROWN	
40. SIGNATURE OF PHYSICIAN DR. J. SMITH		41. SIGNATURE OF REGISTRAR JOHN J. BROWN		42. SIGNATURE OF WITNESSES JOHN J. BROWN	
43. SIGNATURE OF DECEASED JOHN J. BROWN		44. SIGNATURE OF PHYSICIAN DR. J. SMITH		45. SIGNATURE OF REGISTRAR JOHN J. BROWN	
46. SIGNATURE OF WITNESSES JOHN J. BROWN		47. SIGNATURE OF DECEASED JOHN J. BROWN		48. SIGNATURE OF PHYSICIAN DR. J. SMITH	
49. SIGNATURE OF REGISTRAR JOHN J. BROWN		50. SIGNATURE OF WITNESSES JOHN J. BROWN		51. SIGNATURE OF DECEASED JOHN J. BROWN	
52. SIGNATURE OF PHYSICIAN DR. J. SMITH		53. SIGNATURE OF REGISTRAR JOHN J. BROWN		54. SIGNATURE OF WITNESSES JOHN J. BROWN	
55. SIGNATURE OF DECEASED JOHN J. BROWN		56. SIGNATURE OF PHYSICIAN DR. J. SMITH		57. SIGNATURE OF REGISTRAR JOHN J. BROWN	
58. SIGNATURE OF WITNESSES JOHN J. BROWN		59. SIGNATURE OF DECEASED JOHN J. BROWN		60. SIGNATURE OF PHYSICIAN DR. J. SMITH	
61. SIGNATURE OF REGISTRAR JOHN J. BROWN		62. SIGNATURE OF WITNESSES JOHN J. BROWN		63. SIGNATURE OF DECEASED JOHN J. BROWN	
64. SIGNATURE OF PHYSICIAN DR. J. SMITH		65. SIGNATURE OF REGISTRAR JOHN J. BROWN		66. SIGNATURE OF WITNESSES JOHN J. BROWN	
67. SIGNATURE OF DECEASED JOHN J. BROWN		68. SIGNATURE OF PHYSICIAN DR. J. SMITH		69. SIGNATURE OF REGISTRAR JOHN J. BROWN	
70. SIGNATURE OF WITNESSES JOHN J. BROWN		71. SIGNATURE OF DECEASED JOHN J. BROWN		72. SIGNATURE OF PHYSICIAN DR. J. SMITH	
73. SIGNATURE OF REGISTRAR JOHN J. BROWN		74. SIGNATURE OF WITNESSES JOHN J. BROWN		75. SIGNATURE OF DECEASED JOHN J. BROWN	
76. SIGNATURE OF PHYSICIAN DR. J. SMITH		77. SIGNATURE OF REGISTRAR JOHN J. BROWN		78. SIGNATURE OF WITNESSES JOHN J. BROWN	
79. SIGNATURE OF DECEASED JOHN J. BROWN		80. SIGNATURE OF PHYSICIAN DR. J. SMITH		81. SIGNATURE OF REGISTRAR JOHN J. BROWN	
82. SIGNATURE OF WITNESSES JOHN J. BROWN		83. SIGNATURE OF DECEASED JOHN J. BROWN		84. SIGNATURE OF PHYSICIAN DR. J. SMITH	
85. SIGNATURE OF REGISTRAR JOHN J. BROWN		86. SIGNATURE OF WITNESSES JOHN J. BROWN		87. SIGNATURE OF DECEASED JOHN J. BROWN	
88. SIGNATURE OF PHYSICIAN DR. J. SMITH		89. SIGNATURE OF REGISTRAR JOHN J. BROWN		90. SIGNATURE OF WITNESSES JOHN J. BROWN	
91. SIGNATURE OF DECEASED JOHN J. BROWN		92. SIGNATURE OF PHYSICIAN DR. J. SMITH		93. SIGNATURE OF REGISTRAR JOHN J. BROWN	
94. SIGNATURE OF WITNESSES JOHN J. BROWN		95. SIGNATURE OF DECEASED JOHN J. BROWN		96. SIGNATURE OF PHYSICIAN DR. J. SMITH	
97. SIGNATURE OF REGISTRAR JOHN J. BROWN		98. SIGNATURE OF WITNESSES JOHN J. BROWN		99. SIGNATURE OF DECEASED JOHN J. BROWN	
100. SIGNATURE OF PHYSICIAN DR. J. SMITH		101. SIGNATURE OF REGISTRAR JOHN J. BROWN		102. SIGNATURE OF WITNESSES JOHN J. BROWN	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF BIRTH
10. OCCUPATION
11. MARITAL STATUS
12. EDUCATION
13. PREVIOUS ILLNESS
14. MEDICATION
15. PHYSICIAN
16. HUSBAND'S NAME
17. CHILDREN
18. SOCIAL SECURITY NUMBER
19. SIGNATURE OF DECEASED
20. SIGNATURE OF PHYSICIAN
21. SIGNATURE OF REGISTRAR
22. SIGNATURE OF WITNESSES
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100. SIGNATURE OF PHYSICIAN
101. SIGNATURE OF REGISTRAR
102. SIGNATURE OF WITNESSES

12150

CERTIFICATE OF DEATH

12098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups Md</u>	
c. LENGTH OF STAY IN 1b <u>46 yrs</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Box 54 - Jessups Md</u>	
e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS <u>Box 54</u>	
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>E. BARONAS</u> Last <u>BARONAS</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1865</u>
9. AGE (In years lost birthday) <u>94</u>		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTH PLACE (State or foreign country) <u>Lettistonia</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Elizabeth Patricia Jessups Md</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>480 X</u> <u>Bronchopneumonia</u> DUE TO <u>Influenza</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gen'l arteriosclerosis</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>1 wk</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/25</u> , 19 <u>57</u> , to <u>11/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/27</u> , 19 <u>59</u> , and that death occurred at <u>10:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>11/30/59</u>			
ACTUAL SIGNATURE <u>J M Warren</u> M.D. <u>—</u>		PHYSICIAN'S NAME (Type) <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Memorial Society Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Schaefer</u> ADDRESS <u>637 Wood Blvd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater				c. LENGTH OF STAY IN 1b Edgewater			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 446				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle W Last BEARD				4. DATE OF DEATH Month NOVEMBER Day 26 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26, 1871	
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 88 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer				10b. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas BEARD				14. MOTHER'S MAIDEN NAME (Unknown) WATERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217 38 3417			
17. INFORMANT Mr. Thomas W. Beard- Son - Same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) coronary artery disease (c) arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-25 , 19 59 , to 11-26 , 19 59 , that I last saw the deceased alive on 11-26 9 A.M. , 19 59 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lothian, Md. DATE SIGNED 11-26-59 ACTUAL SIGNATURE Emily H. Wilson M.D. Lothian, Md. PHYSICIAN'S NAME (Type) Emily Wilson MD Lothian, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 28, 1959			
22c. NAME OF CEMETERY OR CREMATORY Hopping Funeral Home				22d. LOCATION (City, town, or county) (State) Edgewater, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR NOV 30 '59			
24b. REGISTRAR'S SIGNATURE Charles S. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

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Blank form area for death certificate details, including fields for name, date, and location.

FOR STATE HEALTH DEPT.

12111 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12100

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis		d. STREET ADDRESS 1 Chesterfield Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chesterfield Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPHINE Middle M. Last BOEHM				4. DATE OF DEATH Month November Day 15 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 18-1895	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Chesterbrook		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Masek		14. MOTHER'S MAIDEN NAME Anna Lehecka		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. 1-11-111111		17. INFORMANT William A. Boehm		Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Skull fracture 900.0 SUBDURAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subdural hemorrhage DUE TO (c) 900.0 SUBDURAL						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell down steps					
20c. TIME OF INJURY Hour 11:15 p.m. 11/15 1959	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Annapolis	(County) Anne Arundel	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William V. Lovitt, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED 11/17/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-59		22c. NAME OF CEMETERY OR CREMATORY Hellcrest Cent		22d. LOCATION (City, town, or country) (State) Annapolis Md	
23. FUNERAL DIRECTOR John M. Layla Co		ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Gaithersburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SANNS NURSING HOME</i>		d. STREET ADDRESS <i>Route 1 Box 495</i>	
3. NAME OF DECEASED (Type or print) First <i>Blanche B.</i> Middle <i>Boone</i> Last <i>Boone</i>		4. DATE OF DEATH Month <i>November</i> Day <i>18</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 13, 1880</i>
9. AGE (In years last birthday) <i>78</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>5</i> Days <i>5</i> Hours <i>13</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Edmond P. Boone</i>		14. MOTHER'S MAIDEN NAME <i>Maria Smallwood</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>20</i>	
17. INFORMANT <i>Grafton Boone</i>		Address <i>TR. - #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cordis Vascular Disease -</i> DUE TO (c) <i>Hypertensive Cardio Vascular Disease -</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour— <i>a. m.</i> <i>—</i> <i>19</i> <i>p. m.</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 25, 1959</i> , to <i>November 18, 1959</i> , that I last saw the deceased alive on <i>May 17, 1959</i> , and that death occurred at <i>8:00 a. m.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Felix Gunder</i>		ADDRESS (Street, city or town, state) <i>P.O. Box 97 Capeton Md.</i>	
PHYSICIAN'S NAME (Type) <i>Felix Gunder</i>		DATE SIGNED <i>11-18-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-20-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Sayler</i>		ADDRESS <i>Cornapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 23 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>1870</i>	
5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>CLERK</i>	
7. MARITAL STATUS <i>MARRIED</i>		8. PLACE OF DEATH <i>HOME</i>	
9. CAUSE OF DEATH <i>HEART DISEASE</i>		10. TIME OF DEATH <i>10:30 AM</i>	
11. SIGNATURE OF PHYSICIAN <i>J. B. SMITH</i>		12. SIGNATURE OF WITNESSES <i>J. B. SMITH</i>	
13. SIGNATURE OF DECEASED <i>J. B. SMITH</i>		14. SIGNATURE OF FUNERAL HOME <i>J. B. SMITH</i>	
15. SIGNATURE OF COUNTY CLERK <i>J. B. SMITH</i>		16. SIGNATURE OF STATE DEPARTMENT OF HEALTH <i>J. B. SMITH</i>	

12153
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 2,7,9, Film 6252 11-27-59 et
 CERTIFICATE OF DEATH

12102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland		Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		d. STREET ADDRESS R/F/D/H		1425 Belmont St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin Bowie		4. DATE OF DEATH Month Day Year November 15, 19 59		5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?		9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Bowie		14. MOTHER'S MAIDEN NAME Martha Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. INFORMANT EARLY BOWIE WEST RIVER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ? yrs.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile mental changes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from November 17, 19 57, to November 15, 19 59 that I last saw the deceased alive on November 7, 19 59 and that death occurred at 4:45 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED November 16, 1959	
ACTUAL SIGNATURE James M. Pair		M.D. 400 N. Carrollton Ave. Baltimore 23, Md.		PHYSICIAN'S NAME (Type) James M. Pair, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-59		22c. NAME OF CEMETERY OR CREMATORY MT. AUBURN		22d. LOCATION (City, town, or county) BALTIMORE, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE WM. A. JACKSON FUNERAL HOME INC.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12112

CERTIFICATE OF DEATH

Reg. Dist. No.

12103

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis			
f. STREET ADDRESS Rt-1, Box-195				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Lucien Last BRADY				4. DATE OF DEATH Month November Day 15 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1894	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVMT PAY OFF			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James R. Brady				14. MOTHER'S MAIDEN NAME Mary Gable			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES 6-4-17-1-20-19				16. SOCIAL SECURITY NO. INFORMANT Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO 2 yrs (c) 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 56 to Nov 15 , 19 59 , that I last saw the deceased alive on 11-15 , 19 59 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Martin				ADDRESS (Street, city or town, state) 6 Shaw St.,			
PHYSICIAN'S NAME (Type) James R. Martin				DATE SIGNED 11/16/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-17-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY ST MARY'S CEM.		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR SON				ADDRESS ANNAPOLIS MD		24a. REC'D BY REGISTRAR NOV 20 '59	
				24b. REGISTRAR'S SIGNATURE Charles E. Kiser			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1912

And a child

Married

Age

and a child

Annals

2 days

Married - Annals

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Married - Annals

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burne 1 year 10 - 10</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Plaza Manoa Nursing Home</i>		d. STREET ADDRESS <i>515 Shaw St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Benjamin</i> Middle <i>Brook's</i> Last <i></i>		4. DATE OF DEATH Month <i>11</i> Day <i>16</i> Year <i>1959</i>	
5. SEX <i>Mr.</i>	6. COLOR OR RACE <i>C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-25-1879</i>
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-18-5855</i>	
17. INFORMANT <i>Eleanor Williams</i> Address <i>445 East St. Annapolis</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis.</i> <i>332x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3-20</i> , 19 <i>58</i> , to <i>11/16</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>11-12</i> , 19 <i>59</i> , and that death occurred at <i>1:30</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Felix Gruenberg</i>		ADDRESS (Street, city or town, state) <i>P.O. Box 37 Odenton Md</i>	
PHYSICIAN'S NAME (Type) <i>Felix Gruenberg</i>		DATE SIGNED <i>11/16/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-21-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Harwoodsville</i>	22d. LOCATION (City, town, or county) (State) <i>Harwoodsville Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Beesett</i> ADDRESS <i>108 W. 1st St. Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 23 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12105

Reg. Dist. No.

12155

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burne</u>		c. LENGTH OF STAY IN 1b <u>1 year 10m.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>		d. STREET ADDRESS <u>1209 Whitcoat St</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Brooks</u> Last <u>-</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1st</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-1995</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u> Hours <u>4</u> Min.	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RICHARD BROOKS</u>		14. MOTHER'S MAIDEN NAME <u>MARY ROBINSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>LYVENIA WILLIAMS</u>		Address <u>619 W. MULBERRY ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Progressive Neuro-muscular weakness</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-31</u> 19 <u>58</u> , to <u>11-1</u> 19 <u>59</u> , that I last saw the deceased alive on <u>10-23</u> 19 <u>59</u> , and that death occurred at <u>7:40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Felix Gruenberg</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Box 97 Odenton Md</u>	
PHYSICIAN'S NAME (Type) <u>Felix Gruenberg</u>		DATE SIGNED <u>11/1/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>M.T. AUBURN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson Inc.</u>		ADDRESS <u>916 PENNA AVE.</u>	
24a. REC'D BY REGISTRAR <u>Nov 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

(continued)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12106

12113

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Annapolis			
f. STREET ADDRESS Rt-1, Box-69				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mildred Elenore Middle BUECHLING Last BUECHLING				4. DATE OF DEATH Month 11 Day 13 Year 1959			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-6-07	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 5 Days 2 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Harry A. Covey				14. MOTHER'S MAIDEN NAME Gertrude West			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 144 959		17. INFORMANT Charles Buechling		Address Glen Isle Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pulmonary fibrosis DUE TO (c) ??							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb. , 1957, to 13 Nov. , 1959, that I last saw the deceased alive on 13 Nov. , 1959, and that death occurred at 12:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Md. DATE SIGNED 11/13/59 ACTUAL SIGNATURE Edward S. Beck M.D. 4 Southgate Circle PHYSICIAN'S NAME (Type) Edward S. Beck							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12156

CERTIFICATE OF DEATH

12107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 yr. - 8 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>District Training School, Laurel, Md.</u>				STREET ADDRESS <u>1233 Walter Street, S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle _____ Last <u>Campbell</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 27, 1952</u>	
9. AGE (In years last birthday) yrs. _____		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willie Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle Redfearn Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address <u>Children's Center Laurel, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>325.5</u> IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mental retardation - post-birth subdural hematoma</u> DUE TO <u>Convulsive disorder</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> Fro m birth							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/14/58</u> , 19____, to <u>11/5/59</u> , 19____, that I last saw the deceased alive on <u>11/5/59</u> , 19____, and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>James E. Boyland</u> M.D. <u>Children's Center, Laurel, Md.</u> <u>11/6/59</u> PHYSICIAN'S NAME (Type) <u>James E. Boyland, M.D.</u> <u>Children's Center, Laurel, Md.</u> <u>11/6/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>D.T.S. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Moore, Jr.</u>				ADDRESS <u>D.T.S. Laurel, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William D. Frank</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12119

Reg. Dist. No.

12114

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) AA. GENERAL HOSPT.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ARTHUR ROLAND CARR				4. DATE OF DEATH Nov 22 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH SEPT 24 1902		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM SUPPLY STORE		10b. KIND OF BUSINESS OR INDUSTRY MERCHANT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN A. CARR				14. MOTHER'S MAIDEN NAME IRENE KING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MARY E. CARR #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 466X DUE TO (b) Phlebotomies - lower extremities Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE [Signature]				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) [Signature]				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-25-1959		22c. NAME OF CEMETERY OR CREMATORY EDWARDS CHAPEL		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR SON ADDRESS ANNAPOLIS MD				24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12157

CERTIFICATE OF DEATH

12110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 11mo. 9 days				d. STREET ADDRESS 409 Durham Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle (Louis) Last Carter				4. DATE OF DEATH Month 11 Day 23 Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1903	
9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Hauler				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joe Carter				14. MOTHER'S MAIDEN NAME Ida			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - Gangrene both legs				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from 12/14 , 19 55 , to 11/23 , 19 59 , that I last saw the deceased alive on 11/23 , 19 59 , and that death occurred at 6:30 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 11/24/59							
ACTUAL SIGNATURE Hildegard Heard Reissman M.D.				PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 11/24/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem		22d. LOCATION (City, town, or county) (State) Ann Arundel Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Lick Jr. Balt.				24a. REC'D BY REGISTRAR DATE NOV 30 59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

M

1

FILE IN DEATH FILES

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH Jan 15 1850		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH Dec 10 1915		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF PHYSICIAN J. H. Harris	
16. SIGNATURE OF NEXT OF KIN J. H. Harris		17. SIGNATURE OF REGISTRAR J. H. Harris		18. SIGNATURE OF CLERK J. H. Harris		19. SIGNATURE OF JURY J. H. Harris		20. SIGNATURE OF JUDGE J. H. Harris	

may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12115

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12115

CERTIFICATE OF DEATH

12111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Counties</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Counties</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 S. Villa Ave.</u>				d. STREET ADDRESS <u>102 S. Villa Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Bessie A. Chambers</u>				4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1922</u>	9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson Sellman</u>				14. MOTHER'S MAIDEN NAME <u>Leatha Jarvis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>John W. Chambers</u>		INFORMANT Address <u>102 S. Villa Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 153.8 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-5-59</u> , 19 <u>59</u> , to <u>11-19-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-15-59</u> , 19 <u>59</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. J. Allen</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>11-20-59</u>			
PHYSICIAN'S NAME (Type) <u>A. J. ALLEN</u>				M.D. <u>C. L. Cochran</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash. St. Annapolis</u>				24. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

HEAD OF DEPARTMENT

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12158

CERTIFICATE OF DEATH

12112

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>44 yr. 9mo. 11</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>da. Annapolis 10</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>UNKNOWN</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Colbert</u> Last <u>Colbert</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	IF UNDER 24 HRS. Hours <u>78</u> Min. <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Colbert</u>		14. MOTHER'S MAIDEN NAME <u>Emmaly Duckett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO <u>Hypertensive and Arteriosclerotic Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 17,</u> 19 <u>16,</u> to <u>Nov. 30,</u> 19 <u>59,</u> that I last saw the deceased alive on <u>Nov. 30,</u> 19 <u>59,</u> and that death occurred at <u>8:37 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. Ludwig Benedict, M.D.</u>		<u>Crownsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12.2.59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>12-2-59</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 4 '59

Arthur S. Kraus

12116

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 118 Granville Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle B Last COLBURN, Sr.				4. DATE OF DEATH Month November Day 24, Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 9, 1888	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Painter				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Milton Colburn				14. MOTHER'S MAIDEN NAME Mary Jane Riggel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs Esther Hall Colburn- Wife- same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from July , 1957, to Nov , 1957, that I last saw the deceased alive on Nov 24 , 1957, and that death occurred 10:10PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral St., DATE SIGNED 11/25/59 ACTUAL SIGNATURE John L. Hedeman M.D. 121 Cathedral St., 11/25/59 PHYSICIAN'S NAME (Type) John L. Hedeman Annapolis, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Nov. 27, 1959 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery 22d. LOCATION (City, town, or county) (State) Annapolis, Md. 23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md. 24a. REC'D BY REGISTRAR NOV 30 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

492 F. J. Beck

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 14 Film G253 12-24-59 et
 12159 CERTIFICATE OF DEATH

12114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN lb 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snowhill d. STREET ADDRESS 204 Collins Street e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Irene Collick				4. DATE OF DEATH Month Day Year 11 16 1959			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1917	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Collick				14. MOTHER'S MAIDEN NAME Lillian (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 352x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubitus ulcers DUE TO (c) Spastic hemaparesis, disorganized convulsions						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. - - 19 p. m. - - -	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) -----	(County) -----	(State) -----		
21. I certify that I attended the deceased from 10/27 , 19 59 , to 11/16 , 19 59 , that I last saw the deceased alive on 11/16 , 19 59 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Hildegard Heard Reissman M.D. Crownsville State Hospital, Md. 11/16/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D. Crownsville State Hospital, Md. 11/16/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 19/59	22c. NAME OF CEMETERY OR CREMATORY Edgewood		22d. LOCATION (City, town, or county) (State) Snow Hill Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Chas E. Hick		ADDRESS 43-45 North West		24a. REC'D BY REGISTRAR DATE NOV 19 59	24b. REGISTRAR'S SIGNATURE Arthur S. Harris		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12160

CERTIFICATE OF DEATH

Reg. Dist. No.

12115

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (RFD)</u>		c. LENGTH OF STAY IN 1b <u>23 yrs. +</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena R.F.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Poplar Ridge Road</u>				d. STREET ADDRESS <u>Poplar Ridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHRISTIAN</u> First <u>ANDREW</u> Middle <u>(Roch)</u> <u>COOK</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 Sept. 1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Koch</u>				14. MOTHER'S MAIDEN NAME <u>Lena Elkus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-3977</u>		17. INFORMANT <u>W. Hark Shanks</u>		Address <u>Poplar Ridge Rd, Pasadena, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>CARCINOMA RECTUM</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>6 MONTHS</u> <u>15 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>AUGUST</u> 19 <u>59</u> , to <u>NOVEMBER</u> 19 <u>59</u> , that I last saw the deceased alive on <u>NOVEMBER 15, 1959</u> , and that death occurred at <u>2:45AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>11-17-59</u>							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>				M.D. <u>MOUNTAIN RD.</u>			
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>				<u>PASADENA, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>20 Nov. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Maryth Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pasadena RFD, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>				ADDRESS <u>Shenandoah, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	
24a. REC'D BY REGISTRAR <u> </u>				DATE <u>NOV 20 '59</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		12-1-28		MEMPHIS, TENN		4-4-68		MEMPHIS, TENN		10:00 AM		HEART DISEASE		NATURAL		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY	
16. OCCUPATION		17. EDUCATION		18. MARITAL STATUS		19. RELIGION		20. PREVIOUS ILLNESS		21. PREVIOUS SURGERY		22. PREVIOUS TRAUMA		23. PREVIOUS DRUGS		24. PREVIOUS ALCOHOL		25. PREVIOUS TOBACCO		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER		29. PREVIOUS OTHER		30. PREVIOUS OTHER	
SALES		HIGH SCHOOL		MARRIED		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED		37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED		43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED	
J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY	

1

1

1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. DATE OF DEATH
8. PLACE OF DEATH
9. TIME OF DEATH
10. CAUSE OF DEATH
11. MANNER OF DEATH
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF REGISTRAR
14. SIGNATURE OF WITNESS
15. SIGNATURE OF DECEASED
16. OCCUPATION
17. EDUCATION
18. MARITAL STATUS
19. RELIGION
20. PREVIOUS ILLNESS
21. PREVIOUS SURGERY
22. PREVIOUS TRAUMA
23. PREVIOUS DRUGS
24. PREVIOUS ALCOHOL
25. PREVIOUS TOBACCO
26. PREVIOUS OTHER
27. PREVIOUS OTHER
28. PREVIOUS OTHER
29. PREVIOUS OTHER
30. PREVIOUS OTHER
31. SIGNATURE OF DECEASED
32. SIGNATURE OF DECEASED
33. SIGNATURE OF DECEASED
34. SIGNATURE OF DECEASED
35. SIGNATURE OF DECEASED
36. SIGNATURE OF DECEASED
37. SIGNATURE OF DECEASED
38. SIGNATURE OF DECEASED
39. SIGNATURE OF DECEASED
40. SIGNATURE OF DECEASED
41. SIGNATURE OF DECEASED
42. SIGNATURE OF DECEASED
43. SIGNATURE OF DECEASED
44. SIGNATURE OF DECEASED
45. SIGNATURE OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12161

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Cape May			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cape May 67 X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 810 Riverside Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Steven Michael Dadez				4. DATE OF DEATH November 14th. 19 59			
5. SEX M	6. COLOR OR RACE Hawaian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/59		9. AGE (In years last birthday) 3 yrs. 12 mos. 12 days	IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cape May Court House, N.J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ricarte Dadez				14. MOTHER'S MAIDEN NAME Dorothy E. Koutz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr and Mrs R. Dadez (parents.)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation DUE TO Conditions, if any, which gave rise to immediate cause (b) 9240 (c) 9240 DUE TO c) stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Baby was sleeping on his belly, his head covered with a blanket.					
20c. TIME OF INJURY Month, Day, Year 9 A.M. 11/14/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In his own carriage. 810 Riverside Rd. A.A. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 11/14/59			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		11-16-59		Parkwood Cem.		Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John C. Miller Inc. 2431 E. Oliver St.				24a. REC'D BY REGISTRAR NOV 17 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		DATE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]		PRESENT ILLNESS [REDACTED]	
PHYSICIAN'S SIGNATURE [REDACTED]		MEDICAL EXAMINER'S SIGNATURE [REDACTED]		JURY'S SIGNATURE [REDACTED]	
COUNTY OF [REDACTED]		CITY OF [REDACTED]		STATE OF [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12117

12117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>141 Spa View Ave</i>		d. STREET ADDRESS <i>141 Spa View Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Margaret Ann Williams Daniel</i>		4. DATE OF DEATH Month Day Year <i>Nov 14 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 19 1874</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher Ret.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Public School</i>	
11. BIRTHPLACE (State or foreign country) <i>Frostburg Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James D. Williams</i>		14. MOTHER'S MAIDEN NAME <i>Leviah Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Miss Leviah Daniel</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute dilatation of the heart</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio Vascular</i> DUE TO <i>Disease</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Dilatation of the left foot</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 1, 1954</i> to <i>Nov. 14, 1959</i> that I last saw the deceased alive on <i>Nov. 14, 1959</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Albert R. Anderson</i>		ADDRESS (Street, city or town, state) <i>44 South Gate Ave - Annapolis, Md</i>	
DATE SIGNED <i>11/16/59</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-17-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Frostburg Memorial Pk</i>		22d. LOCATION (City, town, or county) (State) <i>Frostburg Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Scayler Sms</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 20 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

27. 1892. 1011 1012 1013

James M. Smith

11-11 22

1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right.

1874

Handwritten signature: *John W. Smith*

11/11/11

Handwritten text, likely bleed-through from the reverse side of the page.

Y-11217-11321

1. The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation

12118

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HOMEWOOD CONVALESCENT HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE HAASE DAVEY</u>		4. DATE OF DEATH Month Day Year <u>NOV 23 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1880</u> yrs. <u>79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		17. INFORMANT Address <u>BERNARD C. HOFF 106 #2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 1955</u> , to <u>23 NOV 1959</u> , that I last saw the deceased alive on <u>23 NOV 1959</u> , and that death occurred at <u>3:34 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>4 Southgate Ave</u> DATE SIGNED <u>11/24/59</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>NOV 26, 1959</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST MEM.</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>JOHN M. TAYLOR-SON ANNAPOLIS MD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12119

12120

1. PLACE OF DEATH o. COUNTY <i>a a</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b <i>82 yrs</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>a a</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thomas Franklin Deale</i> First Middle Last 4. DATE OF DEATH <i>Nov 1 1959</i> Month Day Year		5. SEX <i>Male</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>JAN 1 1877</i> 9. AGE (In years last birthday) <i>82</i> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Waterman Railway</i> 11. BIRTHPLACE (State or foreign country) <i>DEALE, Md.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>JAMES DEALE</i> 14. MOTHER'S MAIDEN NAME <i>ELIZABETH CRUTCHLEY</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> 16. SOCIAL SECURITY NO. <i>none</i> INFORMANT <i>Mrs Margaret A. Phipps Deale, wid</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-30-59</i> to <i>11-1-59</i> , 19 <i>59</i> that I last saw the deceased alive on <i>11-1-59</i> , 19 <i>59</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Frank M. Shipley</i> M.D. <i>121 Cathedral St 11-1-59</i> PHYSICIAN'S NAME (Type) <i>Frank M. Shipley Annapolis, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>11-3-59</i> 22c. NAME OF CEMETERY OR CREMATORY <i>DEALE cemetery</i> 22d. LOCATION (City, town, or county) (State) <i>DEALE Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel Hardisty Kuleville, Md</i> 24a. REC'D BY REGISTRAR DATE <i>NOV 4 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

18113

my

8-14-10

James Franklin Deale

Male, white, born 10-17-47

Retired Western Railway

James Deale Elizabeth Crutchfield

my

8-14-10

8-14-10

8-14-10

8-14-10

8-14-10

8-14-10

8-14-10

8-14-10

8-14-10

8-14-10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12163

CERTIFICATE OF DEATH

Reg. Dist. No.

12121

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>aa</i> STATE <i>md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillsmere Shores</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillsmere Shores</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>R. F. D. Annapolis Md</i>				d. STREET ADDRESS <i>R. F. D. Annapolis Md</i>			
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>P.</i> Last <i>Drake Sr.</i>				4. DATE OF DEATH Month <i>11</i> Day <i>21</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 26-1904</i>	
9. AGE (In years last birthday) <i>33</i> yrs.		IF UNDER 1 YEAR Months <i>33</i> Days <i>33</i> Hours <i>33</i> Min.		IF UNDER 24 HRS. Months <i>33</i> Days <i>33</i> Hours <i>33</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard at 446 jail</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Guard</i>		11. BIRTHPLACE (State or foreign country) <i>Greensboro Alb</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>							
13. FATHER'S NAME <i>WALTER W. DRAKE</i>				14. MOTHER'S MAIDEN NAME <i>MAMMIE WILKERSON</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>				16. SOCIAL SECURITY NO. <i>Joseph P. Drake Jr.</i>			
17. INFORMANT <i>(2)</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Disease</i> DUE TO <i>Angina Pectoris</i> (c) <i>2-3 yr.</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2-3 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank M Shipley</i>				ADDRESS (Street, city or town, state) <i>121 Cathedral St</i>			
PHYSICIAN'S NAME (Type) <i>Frank M Shipley Annapolis Md</i>				DATE SIGNED <i>11-23-59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>Nov 24-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cent</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Geo Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sr</i>				ADDRESS <i>Annapolis Md</i>			
24a. REC'D BY REGISTRAR <i>NOV 27 '59</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Adrian & Kross

12132

CERTIFICATE OF DEATH

12132

Blank form with faint lines and text, likely a death certificate template. The text is mostly illegible due to fading and bleed-through from the reverse side.

Nov 14 1927
Miss Mary
Miss Mary

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A. do.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Alco.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seyvern Grove Annapolis</i>		c. LENGTH OF STAY IN lb <i>Md 4925.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Seyvern Grove</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>A.</i> Last <i>Dunn</i>		4. DATE OF DEATH Month <i>11</i> Day <i>8</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 20 - 1882</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Joseph Harris</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Pritchard</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>John E Dunn</i>		Address <i>Annapolis, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Arteriosclerosis</i> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Sudden</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John E Dunn</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 11, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville Maryland.</i>	
24a. REC'D BY REGISTRAR <i>NOV 10 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

Page 4
TO HOSPITAL OR A PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
12166					12124														
CERTIFICATE OF DEATH																			
Reg. Dist. No.																			
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George's														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville					c. LENGTH OF STAY IN 1b 1 mo. 17 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville 16X-2									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital					d. STREET ADDRESS Unknown					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First William Middle T. Last Edwards					4. DATE OF DEATH Month 11 Day 14 Year 19 59														
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1877		9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months 11 Days 14		IF UNDER 24 HRS. Hours 19 Min. 59							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer					10b. KIND OF BUSINESS OR INDUSTRY -----					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Williams					14. MOTHER'S MAIDEN NAME Sarah														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. Unknown					INFORMANT Hospital Records Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Arteriosclerotic Heart Disease										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Arteriosclerosis-										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----														
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 17					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----					20f. (City or town) (County) (State) -----				
21. I certify that I attended the deceased from 9/27 , 19 50 , to 11/14 , 19 59 , that I last saw the deceased alive on 11/14 , 19 59 , and that death occurred at 2:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 11/16/59 ACTUAL SIGNATURE Hildegard Heard Reissman M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 11/16/59																			
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/25/59					22b. DATE THEREOF 11/25/59					22c. NAME OF CEMETERY OR CREMATORY University of Maryland					22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese II ADDRESS 108 W. Washington					24a. REC'D BY REGISTRAR NOV 27 '59					24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

CERTIFICATE OF DEATH

1918

11

1

11/25/18
11/25/18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12167

CERTIFICATE OF DEATH

12125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft. G. Mzadz.</u>		c. LENGTH OF STAY IN Tb <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FATH, KATHERINE ELIZABETH</u>		4. DATE OF DEATH <u>Nov. 15 1959.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Nov 1959.</u>
9. AGE (In years last birthday) <u>—</u> yrs.		10. IF UNDER 1 YEAR <u>3</u> Months <u>5</u> Days <u>—</u> Hours <u>—</u> Min.	11. IF UNDER 24 HRS. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DNA.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DNA.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA N. - F.G.G.M.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gordon A. FATH.</u>		14. MOTHER'S MAIDEN NAME <u>Barbara A. Harmon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>FATHER</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>773.5</u> DUE TO <u>Hyaline membranous disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Prematurity.</u> (b) <u>30 hrs.</u> (c) <u>3 days.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 Nov</u> , 19 <u>59</u> , to <u>15 Nov</u> , 19 <u>59</u> that I last saw the deceased alive on <u>15 Nov.</u> , 19 <u>59</u> , and that death occurred at <u>1130 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William W. Miller</u>		ADDRESS (Street, city or town, state) <u>USA N. Ft G. Mzadz.</u> DATE SIGNED <u>15 Nov 59</u>	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 17, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HUGHES TOWN, PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>		ADDRESS <u>4001 Ritchie Hwy.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	
DATE <u>NOV 18 '59</u>			

2050244XUD

BULB 25, MD

A dark, irregular ink blot or smudge on a light-colored, textured surface. The blot is roughly oval-shaped with jagged edges and a dense, dark interior. It is positioned in the lower-middle section of the image. To its right, there is a smaller, lighter, and more diffuse smudge. The background is a light, off-white color with a visible vertical crease or fold line running down the center. There are some faint, dark specks and marks scattered across the surface, particularly near the top and bottom edges.

12168

12126

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklyn.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>50 Brooklyn.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>200 Green PK Rd.</i>		d. STREET ADDRESS <i>200 Green PK Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Michael B Freeze</i>		4. DATE OF DEATH Month <i>11-10</i> Day <i>19</i> Year <i>59.</i>	
5. SEX <i>m.</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-2-85</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ind.</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Thomas.</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET J. ...</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Family - Same</i>	
17. MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>410X cardiac - mitral insuff.</i> DUE TO <i>atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March</i> 1957, to <i>11-10</i> 1959, that I last saw the deceased alive on <i>11-10</i> 1959, and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3904 S. Hanover</i> DATE SIGNED <i>11-12-59</i> ACTUAL SIGNATURE <i>Eugene Schnitzer</i> M.D. PHYSICIAN'S NAME (Type) <i>Eugene Schnitzer, M.D.</i> <i>Baltimore 25, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		22b. DATE THEREOF <i>11/14/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Green Haven</i>		22d. LOCATION (City, town, or county) (State) <i>Booth</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McLurey - 130 E. Fort Cas.</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>NOV 16 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

1912

1912

1

12169

12127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena(Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 299, Bar Harbor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Fuller Last Fuller		4. DATE OF DEATH Month Nov. Day 2, Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1880
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J. Warren Fuller	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 212-09-0495		17. INFORMANT Address Mrs Emma Long, Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			INTERVAL BETWEEN ONSET AND DEATH 2 days Several years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 10, 1959 to November 2, 1959 , that I last saw the deceased alive on November 1, 1959 , and that death occurred at 5:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED REDS Box 442 Pasadena, Md. Nov 2, 1959			
ACTUAL SIGNATURE Randall M. McLaughlin M.D.		PHYSICIAN'S NAME (Type) Randall M. McLaughlin	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR NOV 5 '59	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
CITY [Illegible]		COUNTY [Illegible]		STATE [Illegible]	



THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A REGISTRAR OF THE DEPARTMENT OF HEALTH, AND WHEN THE DEATH HAS BEEN REPORTED TO THE DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12170

CERTIFICATE OF DEATH

13247

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALT. CITY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 1237 LOMBARD ST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 CARROLL RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSARIA</u> Middle <u>(N)</u> Last <u>GIANFORTE</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 FEB. 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>SEBILY, ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>YES - USA</u>	
13. FATHER'S NAME <u>Mr. Dominick Marino (dec)</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Rosaria Battaglia (dec)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MRS. ANTONINA DUVALL-1003 OLD ANNE BURNIE</u>		Address <u>GLEN BURNIE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY THROMBOSIS</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>ADVANCED AGE</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>70 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CANCER - BOTH LUNGS - 3 YRS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>20 Nov</u> , 19 <u>59</u> , to <u>21 Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>20 Nov</u> , 19 <u>59</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.F. Manuzak</u>		ADDRESS (Street, city or town, state) <u>EASTWAY & EDGERLY RD</u>	
PHYSICIAN'S NAME (Type) <u>H.F. MANUZAK</u>		DATE SIGNED <u>21 Nov 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 25-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Demond G Frank</u>		ADDRESS <u>Glen Burnie Md</u>	
24a. REC'D BY REGISTRAR <u>DATE NOV 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-1-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Singer		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. DECEASED AT HOME <input checked="" type="checkbox"/>		12. DECEASED IN HOSPITAL <input type="checkbox"/>		13. DECEASED IN NURSING HOME <input type="checkbox"/>		14. DECEASED IN OTHER PLACE <input type="checkbox"/>		15. PLACE OF DEATH Mobile, Ala.	
16. DATE OF DEATH 4-4-68		17. TIME OF DEATH 11:00 AM		18. CAUSE OF DEATH Heart Disease		19. MANNER OF DEATH Natural		20. SIGNATURE OF PHYSICIAN J. H. Smith	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESSES John Doe, Jane Doe		23. SIGNATURE OF FUNERAL HOME ABC Funeral Home		24. SIGNATURE OF COUNTY CLERK John Doe		25. SIGNATURE OF STATE CLERK John Doe	

THIS CERTIFICATE IS VALID FOR THE STATE OF MARYLAND ONLY. IT IS NOT VALID FOR OTHER STATES OR COUNTRIES. IT IS THE RESPONSIBILITY OF THE DECEASED TO PROVIDE ACCURATE INFORMATION. IF THE DECEASED IS A NATURALIZED CITIZEN, HE OR SHE MUST PROVIDE THE DATE AND PLACE OF NATURALIZATION. IF THE DECEASED IS A NATURALIZED CITIZEN, HE OR SHE MUST PROVIDE THE DATE AND PLACE OF NATURALIZATION. IF THE DECEASED IS A NATURALIZED CITIZEN, HE OR SHE MUST PROVIDE THE DATE AND PLACE OF NATURALIZATION.

12120

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b X Rural - Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS Gilliam's Corner, Defense Hgwy.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle JORDAN Last GILLIAM		4. DATE OF DEATH Month November Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop. Gilliam Corner		10b. KIND OF BUSINESS OR INDUSTRY Ret. Contractor - Bldg.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William H. Gilliam		14. MOTHER'S MAIDEN NAME Emily Mackey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Informant Lillian J. Gilliam #2	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 539.1 DUE TO (b) Inanition due to respiratory DUE TO (c) obstruction by tight diaphragmatic lying cause lost. branes. Thy gall stones		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic congestive heart failure. Ac. Dehydration of brain due			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 26, 19 59 , to Nov. 27, 19 59 , that I last saw the deceased alive on Nov. 27, 19 59 , and that death occurred at 2:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Maurice Klawans M.D.		ADDRESS (Street, city or town, state) 31 Southgate Ave., DATE SIGNED 11/27/59	
PHYSICIAN'S NAME (Type) Maurice Klawans		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-30-59	22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN	22d. LOCATION (City, town, or county) (State) GLEN BURNE MD.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR DATE DEC 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krawns	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

13150

CERTIFICATE OF DEATH

Anna Grubel

Residence

Anna Grubel

Anna - Grubel

Anna Grubel

Anna Grubel (deceased)

Anna Grubel (deceased)

John

John

John

John

John

John

John

John Grubel (deceased)

John Grubel (deceased)

John Grubel (deceased)

John Grubel (deceased)

John Grubel (deceased)

John Grubel (deceased)

John Grubel (deceased)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12171
CERTIFICATE OF DEATH

12129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anna Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D. C.</u> <u>47x-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>		c. LENGTH OF STAY IN 1b <u>33 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Children's Center, District Training School Laurel, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>M.</u> Last <u>Greenstreet</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1900</u>
9. AGE (In years last birthday) yrs. <u>59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Institution</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abner G. Greenstreet</u>		14. MOTHER'S MAIDEN NAME <u>Mary McKee Greenstreet</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Children's Center, Laurel, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pyelonephritis, epilepsy, mental retardation</u> INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> , to <u>Nov 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>59</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u> DATE SIGNED <u>11/10/59</u>			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut, M.D. Children's Center, Laurel, Md.</u> <u>11/10/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold L. Donaldson</u>		ADDRESS <u>313 Talbot Ave Laurel Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12172

CERTIFICATE OF DEATH

12130

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curtis Bay</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Curtis Bay</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6515 Allenhurst Road</u>		d. STREET ADDRESS <u>6515 Allenhurst Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Hall</u>		4. DATE OF DEATH Month Day Year <u>November 6th. 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March-21st-1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ann Arundel County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Hall</u>		14. MOTHER'S MAIDEN NAME <u>Milvina Kess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Bertha Hall 6715 Allenhurst Road</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Thrombophlebitis Rt. Leg</u> DUE TO (c) <u>Cardio Vascular Disease</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Several hrs</u> <u>Several days</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 10, 1959</u> to <u>Nov. 6, 1959</u> , that I last saw the deceased alive on <u>Nov. 5, 1959</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Hunt</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1607 W. Mulberry St. Baltimore 4-7-59</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. HUNT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Choyou Wilson</u>		24a. REG. BY REGISTRAR <u>Nov 8 1959</u>	
ADDRESS <u>1008 Stanton Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Ernest L. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

W. KYLAND STATE BOARD OF HEALTH—JANUARY 19

12121

CERTIFICATE OF DEATH

12131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle Mae Last HARDESTY		4. DATE OF DEATH Month November Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 1, 1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop		10b. KIND OF BUSINESS OR INDUSTRY General Store	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nemiah Brundage		14. MOTHER'S MAIDEN NAME Lillie C. Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no8 (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-34-1980	
17. INFORMANT Mr. Milton Hardesty-Son- Churchton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the bladder DUE TO (c) 6mo		INTERVAL BETWEEN ONSET AND DEATH 1mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 59 , to Nov. 11 , 19 59 , that I last saw the deceased alive on Nov. 10 , 19 59 , and that death occurred at 1:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 98 Cathedral St., Annapolis, Md. DATE SIGNED 11/11/59			
ACTUAL SIGNATURE Edwin Davis, Jr. M.D.		SIGNATURE OF REGISTRAR Arthur L. Kraus	
PHYSICIAN'S NAME (Type) Edwin Davis, Jr.		NAME (Type) Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 13, 1959	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Maryland	
24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12181

CERTIFICATE OF DEATH

12181

John Doe

John Doe

John Doe

John Doe

John Doe

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John Doe

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John Doe

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
12173					CERTIFICATE OF DEATH				
Reg. Dist. No. 12132									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>			c. LENGTH OF STAY IN 1b <u>5½</u> hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>					d. STREET ADDRESS <u>7006-C Antelak St. Argonne Hills</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>-</u> Last <u>HARPER</u>			4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>19 59</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>27 November 1959</u>		9. AGE (In years last birthday) <u>5½</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		
13. FATHER'S NAME <u>Emanuel Harper</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Smith</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>I</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Emanuel Harper (Father)</u>		Address <u>7006-C Antelak St Argonne Hills</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>5½</u> hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>27 Nov</u> , 19 <u>59</u> , to <u>28 November, 1959</u> , that I last saw the deceased alive on <u>28 November</u> , 19 <u>59</u> , and that death occurred at <u>0230 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>28 Nov 1959</u> ACTUAL SIGNATURE <u>Archie S. Golden</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>ARCHIE S. GOLDEN, CAPT., MC</u> <u>USAH, Fort George G. Meade, Maryland</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>30 Nov 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laboratory, U.S. Army Hospital, Fort George G. Meade, Md</u>			22d. LOCATION (City, town, or county) _____ (State) _____		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Betty M. Ellis, CAPT., MSC</u>				ADDRESS <u>U.S. Army Hosp. Fort Geo G Meade, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12174 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u> <u>1 mo. 22 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3 Vol. 4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>1512 Druid Hill Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>VERNON</u> Middle <u></u> Last <u>Hudnell</u>				4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17, 1922</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry H. Hudnell</u>				14. MOTHER'S MAIDEN NAME <u>Celestine Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-12-3599</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>570.5</u> IMMEDIATE CAUSE (a) <u>Paralytic Ileus</u> DUE TO <u>Intestinal Obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Old Post-Operative Adhesions</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. W. H. K. H.</u>		EXAMINER'S NAME (Type) <u>E. L. W. H. K. H.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/4/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parson Memorial Pk</u>		22d. LOCATION (City, town, or county) (State) <u>Manassas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Stice</u>		ADDRESS <u>661 W. Barry St.</u>		24a. REC'D BY REGISTRAR <u>Nov 6 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12133

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, illegible]		SEX [Faint text, illegible]		AGE [Faint text, illegible]	
PLACE OF BIRTH [Faint text, illegible]		OCCUPATION [Faint text, illegible]		CAUSE OF DEATH [Faint text, illegible]	
DATE OF DEATH [Faint text, illegible]		TIME OF DEATH [Faint text, illegible]		PLACE OF DEATH [Faint text, illegible]	
SIGNATURE OF MEDICAL EXAMINER [Faint text, illegible]		SIGNATURE OF WITNESS [Faint text, illegible]		SIGNATURE OF DECEASED [Faint text, illegible]	
CERTIFICATE NO. [Faint text, illegible]		COUNTY [Faint text, illegible]		CITY [Faint text, illegible]	
STATE [Faint text, illegible]		ZIP CODE [Faint text, illegible]		TELEPHONE [Faint text, illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 253 11-26-59 ams

12122

CERTIFICATE OF DEATH

12134

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND		c. LENGTH OF STAY IN 1b ANNAPOLIS, MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Jerome Last JACOBSON		4. DATE OF DEATH Month 11 Day 10 Year 19 59	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-86
9. AGE (In years last birthday) 73 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JACOBSON, Jacob		14. MOTHER'S MAIDEN NAME GANNON, Margaret	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 20 Yrs.	
17. INFORMANT Lillian D. JACOBSON (W)		Address Annapolis, Md. 75 Prince George St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PHNEMONIA 502.0 DUE TO Chronic Pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic bronchitis (c) 20 +		INTERVAL BETWEEN ONSET AND DEATH 4 days XXXXXX 20 +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15 , 19 59 , to Nov 10 , 19 59 , that I last saw the deceased alive on Nov-10 , 19 59 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. BUSCH LT MC USN		ADDRESS (Street, city or town, state) USNH - Annapolis Md.	
PHYSICIAN'S NAME (Type) S. BUSCH LT MC USN		DATE SIGNED NOV 16 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-59	
22c. NAME OF CEMETERY OR CREMATORY National		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN H. TAYLOR & SONS, ANNAPOLIS, MD.		24. REC'D BY REGISTRAR NOV 16 1959	
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12175

Items 8, 9, Film 254 1-13-60 et

Reg. Dist. No.

13262

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>3Y01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>12 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville - State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leon</u> Middle <u>Samison</u> Last <u>Samison</u>		4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1925??</u>
9. AGE (In years last birthday) <u>34?</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>
12. CITIZEN OF WHAT COUNTRY? <u>---</u>		13. FATHER'S NAME <u>Samuel Samison</u>	
14. MOTHER'S MAIDEN NAME <u>EVONNE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>	
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Circulatory Failure</u> <u>795.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Exposure to cold and starvation</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>just before</u> <u>10-30 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John Hackett</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crownsville State Hosp.</u>		22d. LOCATION (City, town, or county) (State) <u>Crownsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar J. del Campo M.D.</u> <u>Crownsville State Hospital</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>	

MEDICAL CERTIFICATION

2

510

1

2

12123

CERTIFICATE OF DEATH

12135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H.A. GENERAL Hospital</u>				d. STREET ADDRESS <u>RIVA RD Rt #1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE MAY JOHNSON</u>				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-1910</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROY HEWITT</u>				14. MOTHER'S MAIDEN NAME <u>"LUCK"</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ROY L. JOHNSON</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Mon</u> <u>yr -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Staph pneumonia, old myocardial infarct</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> 19 <u>—</u> , to <u>11-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-6-59</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Frank M Shipley</u> M.D. <u>171 Cathedral St</u>				<u>11-9-59</u>			
PHYSICIAN'S NAME (Type) <u>Frank M Shipley Annapolis, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Long & Sons Annapolis, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12137

CERTIFICATE OF DEATH

12137

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. PLACE OF DEATH a. HOME		2. PLACE OF DEATH b. HOSPITAL	
3. DATE OF DEATH JAN 10 1968		4. TIME OF DEATH 10:00 AM	
5. SEX M		6. AGE 65	
7. RACE W		8. MARITAL STATUS M	
9. OCCUPATION RETIRED		10. CAUSE OF DEATH HEART DISEASE	
11. MANNER OF DEATH NATURAL		12. SIGNATURE OF PHYSICIAN J. H. SMITH	
13. SIGNATURE OF REGISTRAR J. H. SMITH		14. SIGNATURE OF WITNESS J. H. SMITH	
15. SIGNATURE OF WITNESS J. H. SMITH		16. SIGNATURE OF WITNESS J. H. SMITH	
17. SIGNATURE OF WITNESS J. H. SMITH		18. SIGNATURE OF WITNESS J. H. SMITH	
19. SIGNATURE OF WITNESS J. H. SMITH		20. SIGNATURE OF WITNESS J. H. SMITH	
21. SIGNATURE OF WITNESS J. H. SMITH		22. SIGNATURE OF WITNESS J. H. SMITH	
23. SIGNATURE OF WITNESS J. H. SMITH		24. SIGNATURE OF WITNESS J. H. SMITH	
25. SIGNATURE OF WITNESS J. H. SMITH		26. SIGNATURE OF WITNESS J. H. SMITH	
27. SIGNATURE OF WITNESS J. H. SMITH		28. SIGNATURE OF WITNESS J. H. SMITH	
29. SIGNATURE OF WITNESS J. H. SMITH		30. SIGNATURE OF WITNESS J. H. SMITH	
31. SIGNATURE OF WITNESS J. H. SMITH		32. SIGNATURE OF WITNESS J. H. SMITH	
33. SIGNATURE OF WITNESS J. H. SMITH		34. SIGNATURE OF WITNESS J. H. SMITH	
35. SIGNATURE OF WITNESS J. H. SMITH		36. SIGNATURE OF WITNESS J. H. SMITH	
37. SIGNATURE OF WITNESS J. H. SMITH		38. SIGNATURE OF WITNESS J. H. SMITH	
39. SIGNATURE OF WITNESS J. H. SMITH		40. SIGNATURE OF WITNESS J. H. SMITH	
41. SIGNATURE OF WITNESS J. H. SMITH		42. SIGNATURE OF WITNESS J. H. SMITH	
43. SIGNATURE OF WITNESS J. H. SMITH		44. SIGNATURE OF WITNESS J. H. SMITH	
45. SIGNATURE OF WITNESS J. H. SMITH		46. SIGNATURE OF WITNESS J. H. SMITH	
47. SIGNATURE OF WITNESS J. H. SMITH		48. SIGNATURE OF WITNESS J. H. SMITH	
49. SIGNATURE OF WITNESS J. H. SMITH		50. SIGNATURE OF WITNESS J. H. SMITH	
51. SIGNATURE OF WITNESS J. H. SMITH		52. SIGNATURE OF WITNESS J. H. SMITH	
53. SIGNATURE OF WITNESS J. H. SMITH		54. SIGNATURE OF WITNESS J. H. SMITH	
55. SIGNATURE OF WITNESS J. H. SMITH		56. SIGNATURE OF WITNESS J. H. SMITH	
57. SIGNATURE OF WITNESS J. H. SMITH		58. SIGNATURE OF WITNESS J. H. SMITH	
59. SIGNATURE OF WITNESS J. H. SMITH		60. SIGNATURE OF WITNESS J. H. SMITH	
61. SIGNATURE OF WITNESS J. H. SMITH		62. SIGNATURE OF WITNESS J. H. SMITH	
63. SIGNATURE OF WITNESS J. H. SMITH		64. SIGNATURE OF WITNESS J. H. SMITH	
65. SIGNATURE OF WITNESS J. H. SMITH		66. SIGNATURE OF WITNESS J. H. SMITH	
67. SIGNATURE OF WITNESS J. H. SMITH		68. SIGNATURE OF WITNESS J. H. SMITH	
69. SIGNATURE OF WITNESS J. H. SMITH		70. SIGNATURE OF WITNESS J. H. SMITH	
71. SIGNATURE OF WITNESS J. H. SMITH		72. SIGNATURE OF WITNESS J. H. SMITH	
73. SIGNATURE OF WITNESS J. H. SMITH		74. SIGNATURE OF WITNESS J. H. SMITH	
75. SIGNATURE OF WITNESS J. H. SMITH		76. SIGNATURE OF WITNESS J. H. SMITH	
77. SIGNATURE OF WITNESS J. H. SMITH		78. SIGNATURE OF WITNESS J. H. SMITH	
79. SIGNATURE OF WITNESS J. H. SMITH		80. SIGNATURE OF WITNESS J. H. SMITH	
81. SIGNATURE OF WITNESS J. H. SMITH		82. SIGNATURE OF WITNESS J. H. SMITH	
83. SIGNATURE OF WITNESS J. H. SMITH		84. SIGNATURE OF WITNESS J. H. SMITH	
85. SIGNATURE OF WITNESS J. H. SMITH		86. SIGNATURE OF WITNESS J. H. SMITH	
87. SIGNATURE OF WITNESS J. H. SMITH		88. SIGNATURE OF WITNESS J. H. SMITH	
89. SIGNATURE OF WITNESS J. H. SMITH		90. SIGNATURE OF WITNESS J. H. SMITH	
91. SIGNATURE OF WITNESS J. H. SMITH		92. SIGNATURE OF WITNESS J. H. SMITH	
93. SIGNATURE OF WITNESS J. H. SMITH		94. SIGNATURE OF WITNESS J. H. SMITH	
95. SIGNATURE OF WITNESS J. H. SMITH		96. SIGNATURE OF WITNESS J. H. SMITH	
97. SIGNATURE OF WITNESS J. H. SMITH		98. SIGNATURE OF WITNESS J. H. SMITH	
99. SIGNATURE OF WITNESS J. H. SMITH		100. SIGNATURE OF WITNESS J. H. SMITH	

12124

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Debra Middle Ann Last JOHNSON				4. DATE OF DEATH Month November Day 24 Year 19 59			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 8, 1959	
9. AGE (In years last birthday) 2 mos.		10. IF UNDER 1 YEAR Months 2 Days 16 Hours Min. 		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Wick Sylvester Johnson				14. MOTHER'S MAIDEN NAME Theresa Weems			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Theresa Weems 69 Clay St			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X Interstital (Bilateral) Pneumonia DUE TO (b) 5 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20e. (City or town)				20f. (County) (State)			
21. I certify that I attended the deceased from 11/24/59 , 19 59 , to 11/24/59 , 19 59 , that I last saw the deceased alive on 11/24/59 , 19 59 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 110 Clay St., DATE SIGNED 11/25/59 ACTUAL SIGNATURE R. L. Richardson M.D. 110 Clay St., PHYSICIAN'S NAME (Type) R. L. Richardson Annapolis, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11-28-1959				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill				22d. LOCATION (City, town, or county) (State) Annapolis Md			
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #108 Wash St. Annapolis Md				24a. REC'D BY REGISTRAR DATE NOV 30 '59			
24b. REGISTRAR'S SIGNATURE Charles E. Hume							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12130

CENTRAL O-12130

12131

John Marshall

Marshall

John Marshall

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12125

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DOA U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GLEN BURNIE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.				d. STREET ADDRESS 103 BETH ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Donald		Middle E.		Last JOHNSON	
4. DATE OF DEATH		Month 11		Day 10		Year 19 59	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 July 1959		9. AGE (In years last birthday) yrs. 4	IF UNDER 1 YEAR Months 4 Days 7	IF UNDER 24 HRS. Hours 7 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USNH, ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Donald G. JOHNSON				14. MOTHER'S MAIDEN NAME Betty J. HANNA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT (F) Donald G. JOHNSON		Address GLEN BURNIE, (F) Donald G. JOHNSON 103 Beth Rd., MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 754.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COARCTATION OF AORTA DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4 mo. 7 days							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. L. W. HART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 11/10/59					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Nov 12 59	22c. NAME OF CEMETERY OR CREMATORY Mount Vernon		22d. LOCATION (City, town, or county) (State) Annapolis Co Md			
23. FUNERAL DIRECTOR'S SIGNATURE PINK FUNERAL CHAPEL, GLEN BURNIE, MARYLAND				24a. REC'D BY REGISTRAR NOV 16 '59		24b. REGISTRAR'S SIGNATURE Carlton S. House	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2051274XV5

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF DECEASED _____	
DATE OF EXAMINATION _____		PLACE OF EXAMINATION _____	

12126

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lonnie Middle Jesse Last JOHNSON				4. DATE OF DEATH Month November Day 21 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1959		9. AGE (In years last birthday) 16 yrs.	IF UNDER 1 YEAR Months 16 Days 7 Hours 35	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin Roosevelt JOHNSON				14. MOTHER'S MAIDEN NAME Gertrude Beatherlia SELLMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laryngopharyngitis, E. Coli organism 474X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition and dehydration							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> Nov. 20	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) River Club Estates		(County)		(State)	
21. I certify that I attended the deceased from Nov. 5, 1959 , to Nov. 21, 1959 , that I last saw the deceased alive on Nov. 21, 1959 , and that death occurred at 11:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James I. Hudson, Jr.		ADDRESS (Street, city or town, state) River Club Estates		DATE SIGNED 11/23/59			
PHYSICIAN'S NAME (Type) James I. Hudson, Jr.		Edgewater, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-24-1959		22c. NAME OF CEMETERY OR CREMATORY Darlingtonville		22d. LOCATION (City, town, or county) (State) Darlingtonville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #108708		ADDRESS Arma		24a. REC'D BY REGISTRAR NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12128

11

Name (Printed)

John Doe

Age

45 - Male

Residence

1234 Main Street, New York, N.Y.

Sex

Male

Occupation

Teacher

Cause of Death

Heart Disease

1. Myocardial Infarction

2. Coronary Atherosclerosis

Time of Death

11:00 AM

Date of Death

12/12/55

Place of Death

Home

Signature

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY HARFORD ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABERDEEN 1231-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSTOWN STATE HOSP		d. STREET ADDRESS DORSEY AVE	
3. NAME OF DECEASED (Type or print) WILLIAM First KENLY Middle Last		4. DATE OF DEATH Month NOV Day 27 Year 1959	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1879
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William F. Kenly		14. MOTHER'S MAIDEN NAME Tina Peaco	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN - No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Isiah H. Kenly		Address Box 147 Perryman, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CAGHEXIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SENILITY DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 25 NOV , 19 59 , to 27 NOV , 19 59 , that I last saw the deceased alive on 25 NOV , 19 59 , and that death occurred at 2:00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Carl B. Schlufer M.D. CROWNSTOWN STATE HOSP CROWNSTOWN MD. 11/27/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/1959	
22c. NAME OF CEMETERY OR CREMATORY Union Methodist		22d. LOCATION (City, town, or county) (State) Aberdeen Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barring - Aberdeen Md.		24a. REC'D BY REGISTRAR DATE DEC 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

1913

NAME OF DECEASED		DATE OF DEATH	
WILLIAM F. BERRY		JANUARY 10, 1913	
AGE		PLACE OF BIRTH	
38		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
DATE OF INTERMENT		PLACE OF INTERMENT	
JANUARY 12, 1913		BALTIMORE, MARYLAND	
NAME OF FUNERAL HOME		NAME OF MINISTER	
BERRY & SONS		J. P. BERRY	
NAME OF WITNESSES		SIGNATURE OF DECEASED	
J. P. BERRY, J. B. BERRY			
NAME OF PHYSICIAN		NAME OF CLERGYMAN	
J. P. BERRY		J. P. BERRY	
NAME OF REGISTRAR		NAME OF CLERK	
J. P. BERRY		J. P. BERRY	

1913

1913

12127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kyriakos First KOUSERTARY Last		4. DATE OF DEATH November 15 1959 Month November Day 15 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1901
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 5 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTEENDER		10b. KIND OF BUSINESS OR INDUSTRY LUNCH ROOM	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? GREECE	
13. FATHER'S NAME "UOK"		14. MOTHER'S MAIDEN NAME "UOK"	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 8 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Oct. 13, 1959 to Nov. 15, 1959 , that I last saw the deceased alive on Nov. 15, 1959 , and that death occurred at 10:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John L. Hedeman		ADDRESS (Street, city or town, state) 121 Cathedral St., Annapolis, Md.	
PHYSICIAN'S NAME (Type) John L. Hedeman		DATE SIGNED 11/16/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-17-59	
22c. NAME OF CEMETERY OR CREMATORY St. James		22d. LOCATION (City, town, or county) Annapolis (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR NOV 20 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Knease			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12128

CERTIFICATE OF DEATH

12141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ANNAPOLIS d. STREET ADDRESS RD2 BOX 116 ST. MARGARET ST., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAROLD HARRISON LITTLE				4. DATE OF DEATH Month NOVEMBER Day 1 Year 1959			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-89		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME HARRY LITTLE				14. MOTHER'S MAIDEN NAME MARIE BLOODGOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-07-8601A		17. INFORMANT Lillian Little Address RD2 BOX 116, St. Margaret ST., Annapolis, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 190.9 IMMEDIATE CAUSE (a) Melanoma Malignant DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-30 , 19 59 to 11-1 , 19 59 , that I last saw the deceased alive on 31 October , 19 59 , and that death occurred at 0440A M, from the causes and on the date stated above. DATE SIGNED U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. 11-2-59							
ACTUAL SIGNATURE R.C. Laning		M.D. U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.					
PHYSICIAN'S NAME (Type) R.C. LANING LCDR MC USN		U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3, 1959		22c. NAME OF CEMETERY OR CREMATORY Naval Academy Cem.		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hana							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2819

12129

CERTIFICATE OF DEATH

12142

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>120 Granada Ave.</i>		d. STREET ADDRESS <i>120 Granada</i>	
3. NAME OF DECEASED (Type or print) <i>Mary Scala Lorea</i>		4. DATE OF DEATH <i>November 18 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 19, 1888</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Louis Scala</i>		14. MOTHER'S MAIDEN NAME <i>Mary Anna Annanatta</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>17. INFORMANT <i>Mrs. Anne Taylor</i> Address <i>#2</i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIO-SCLEROTIC HEART DISEASE</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 1</i> , 19 <i>54</i> , to <i>18 Nov.</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>18 Nov.</i> , 19 <i>59</i> , and that death occurred at <i>1 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward S. Beck</i> M.D.		ADDRESS (Street, city or town, state) <i>44 Southgate Ave Annapolis Md.</i> DATE SIGNED <i>11/20/59</i>	
PHYSICIAN'S NAME (Type) <i>Edward S. Beck</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-21-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Sons</i> ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 23 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kinne</i>

CERTIFICATE OF DEATH

1914

1914

<p>1. NAME OF DECEASED [Handwritten: John Doe]</p>		<p>2. SEX [Handwritten: Male]</p>	
<p>3. AGE [Handwritten: 45]</p>		<p>4. DATE OF BIRTH [Handwritten: Jan 15, 1869]</p>	
<p>5. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>		<p>6. OCCUPATION [Handwritten: Clerk]</p>	
<p>7. MARITAL STATUS [Handwritten: Married]</p>		<p>8. NAME OF SPOUSE [Handwritten: Jane Doe]</p>	
<p>9. DATE OF DEATH [Handwritten: Dec 10, 1914]</p>		<p>10. TIME OF DEATH [Handwritten: 10:30 AM]</p>	
<p>11. PLACE OF DEATH [Handwritten: Home]</p>		<p>12. CAUSE OF DEATH [Handwritten: Heart Disease]</p>	
<p>13. MEDICAL HISTORY [Handwritten: High blood pressure, diabetes]</p>		<p>14. PRESENT ILLNESS [Handwritten: Angina pectoris]</p>	
<p>15. NAME OF PHYSICIAN [Handwritten: Dr. J. Smith]</p>		<p>16. NAME OF FUNERAL HOME [Handwritten: None]</p>	
<p>17. NAME OF BURIAL PLACE [Handwritten: St. Mary's Cemetery]</p>		<p>18. NAME OF MINISTER [Handwritten: Rev. W. Brown]</p>	
<p>19. NAME OF WITNESS [Handwritten: J. Doe]</p>		<p>20. NAME OF REGISTRAR [Handwritten: A. Jones]</p>	

1

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MD.
 JAN 15 1915

12177

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paul Drive - Box 303				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edna Middle V. Last Lycett				4. DATE OF DEATH Month 11- Day 19- Year 1959			
5. SEX F		6. COLOR OR RACE w		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1886	
9. AGE (In years lost birthday) 73 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Thomas Burke			
14. MOTHER'S MAIDEN NAME Eliz. Sahley				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. —				17. INFORMANT Family Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 151x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from September 15, 1953 to November 19, 1959 , that I last saw the deceased alive on Nov. 19, 1959 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin				ADDRESS (Street, city or town, state) DATE SIGNED Nov. 19, 1959			
PHYSICIAN'S NAME (Type) R. M. McLaughlin				M.D. RF-08 Box 442 Pasadena, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-23-59		22c. NAME OF CEMETERY OR CREMATORY Louisa PK.		22d. LOCATION (City, town, or county) (State) Baltimore, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home				ADDRESS 130 E. Indiana		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12144

12130

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 125 Market St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roberta Middle ELLIOT Last MACALUSO				4. DATE OF DEATH Month November Day 26 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 3, 1906	
9. AGE (In years lost birthday) yrs. 53		IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min.		IF UNDER 24 HRS. Months 53 Days 53 Hours 53 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Nurse				10b. KIND OF BUSINESS OR INDUSTRY Reg Nurse		11. BIRTHPLACE (State or foreign country) TANEXTOWN MD	
12. CITIZEN OF WHAT COUNTRY? U. S A							
13. FATHER'S NAME CHARLES A ELLIOT				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (Yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT MARY Jo LINDSAY Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 Malignant neoplasm of unspecified site (199) DUE TO (b) 7 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 7 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 199.2							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March , 19 59 , to Nov. 26 , 19 59 , that I last saw the deceased alive on Nov. 26 , 19 59 , and that death occurred at 1:05 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Shaw St., DATE SIGNED 11/27/59 ACTUAL SIGNATURE James R. Martin M.D. PHYSICIAN'S NAME (Type) James R. Martin Annapolis, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov 30-59			
22c. NAME OF CEMETERY OR CREMATORY St Mary's Court				22d. LOCATION (City, town, or county) (State) Annapolis Md			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sins				24a. REC'D BY REGISTRAR DATE DEC 1 '59			
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

MEDICAL CERTIFICATION

2

063

M

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CERTIFICATE OF DEATH

13130

John (Armed)

Harvard

John (Armed)

Harvard

Harvard

John (Armed) (Armed) (Armed)

John (Armed) (Armed) (Armed)

Harvard

Harvard

Harvard

Harvard

Harvard

CHARLES A. FRIED
1000 1st St. N.W.
Washington, D.C.

MARY JO LINDSAY

W. J. Lindsey, President of Washington State (199)

John (Armed) (Armed) (Armed)

John (Armed) (Armed) (Armed)

John (Armed) (Armed) (Armed)

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John (Armed) (Armed) (Armed)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12145

12178

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> 47X-3		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Maryland</u>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Children's Center District Training School, Laurel, Md.</u>			d. STREET ADDRESS <u>1404 - 22nd Street S.E.</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>LOIS</u> Middle <u>MAE</u> Last <u>MANN</u>			4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1925</u>		9. AGE (In years last birthday) yrs. <u>34</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Institution</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Isham Wesley Mann</u>			14. MOTHER'S MAIDEN NAME <u>Torpley Mann</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Children's Center, Laurel, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>status epilepticus</u> DUE TO (c) <u>convulsive disorder</u> 2 hrs. 2 yrs.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolian idiosy</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> , to <u>Nov. 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/22/59</u> , 19 <u>59</u> , and that death occurred at <u>1:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u> DATE SIGNED <u>11/24/59</u>					
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u>		M.D. <u>Children's Center, Laurel, Md.</u> 11/24/59			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut, M.D.</u>		<u>Children's Center, Laurel, Md.</u> 11/24/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>D.T.S. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Home, Jr.</u>		ADDRESS <u>DT S Laurel</u>		24a. REC'D BY REGISTRAR <u>NOV 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 10/57

1
12179
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 12 Film G252 11-16-59 et
12146
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY DA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN		c. LENGTH OF STAY IN 1b 50	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 RIVERSIDE RD		d. STREET ADDRESS 108 Riverside Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THOMAS Middle J. Last MC GUIGAN		4. DATE OF DEATH Month 11 Day 8 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 29, 1888
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR: Months 7 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Suburban		10b. KIND OF BUSINESS OR INDUSTRY IRELAND	
11. BIRTHPLACE (State or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mc Guigan		14. MOTHER'S MAIDEN NAME Mc Donald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-01-8797	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: 177X IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) coronary atherosclerosis - Ca protuberans DUE TO (c) lymphoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Thurs , 19 55 , to Nov. 8 , 19 59 , that I last saw the deceased alive on Nov. 8 , 19 59 , and that death occurred at 7:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3904 S. Hanover St. Balto. 25, Md. DATE SIGNED 11-10-59			
ACTUAL SIGNATURE Eugene Schmitzer		M.D. 3904 S. Hanover St. Balto. 25, Md.	
PHYSICIAN'S NAME (Type) Eugene Schmitzer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-11-59	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem		22d. LOCATION (City, town, or county) (State) Brooklyn MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Mc Culley Funeral Hm 130 E State		24a. REC'D BY REGISTRAR DATE NOV 12 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

12180

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sarah Middle Last Miles				4. DATE OF DEATH Month 11 Day 12 Year 19 59			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885?	9. AGE (In years last birthday) yrs. 74?	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown		
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/16 , 19 57 , to 11/12 , 19 59 , that I last saw the deceased alive on 11/12 , 19 59 , and that death occurred on 11/12 , 19 59 , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Hildegard Heard Reissman</i>		ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 11/12/59					
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		Crownsville State Hospital, Md. 11/12/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/16/59		22c. NAME OF CEMETERY OR CREMATORY MT. CALVARY Cem.		22d. LOCATION (City, town, or county) (State) Crownsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Wilson				ADDRESS 1000 Brantley Ave.		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur J. ...</i>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS

1918

County of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12131

CERTIFICATE OF DEATH

12148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL HOSPT.</u>				e. STREET ADDRESS <u>115 CHESTER AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS A. MITCHELL</u>				4. DATE OF DEATH Month Day Year <u>11 23 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 29 1916</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.A.</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>PHILLIP E. MITCHELL</u>				14. MOTHER'S MAIDEN NAME <u>ELSIE MAE DOWNEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>HELEN C. MITCHELL #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>200.1</u> <u>EMACIATION, abdominal obstruction, ascites</u> DUE TO <u>4 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant involvement, abdominal viscera</u> DUE TO <u>3 yrs.</u> (c) <u>Lymphosarcoma, diffuse</u> DUE TO <u>4 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>Nov. 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 23</u> , 19 <u>59</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Merton T. Waite</u> M.D. <u>121 Cathedral St. Annapolis, Md.</u>				DATE SIGNED <u>11-23-59</u>			
PHYSICIAN'S NAME (Type) <u>MERTON T. WAITE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>NOV 27 1959</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST MEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>JOHN M. TAYLOR - SON ANNAPOLIS MD</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Taylor</u>	

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNE ARUNDEL, Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALBERT		4. DATE OF DEATH Month Nov Day 11 Year 1959	
5. SEX Male		6. COLOR OR RACE Col	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-1868	
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab m or Truck M. Nashby Opter Co		12. BIRTHPLACE (State or foreign country) Maryland	
13. CITIZEN OF WHAT COUNTRY? U.S.A.		14. FATHER'S NAME Mose Moberay	
15. MOTHER'S MAIDEN NAME Elizabeth Moberay		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 216-12-6042		18. INFORMANT GERTRUDE MOBRAY HANNAPOLES	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pulmonary & Coronary DUE TO Arteriosclerosis Hypertensive Card Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Ischemic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Scurvy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/23/1959 to 11/11/1959 , that I last saw the deceased alive on 11/11/1959 , and that death occurred at 11/11/1959 M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Rich R. Richman		M.D. 110-CLAY ST. HANNAPOLES, MD. 11/11/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11-1459		22b. DATE THEREOF 11-14-59	
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Chesapeake, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Keese		24. REC'D BY REGISTRAR DATE NOV 17 '59	
ADDRESS 108 Wash. St. Annapolis, Md.		25. REGISTRAR'S SIGNATURE Arthur A. Hanna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12133

CERTIFICATE OF DEATH

12151

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>15 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Bereah L. Mundell</i>				4. DATE OF DEATH Month Day Year <i>Nov. 25th 1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/13, 1883</i>	9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Riverview, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James? Jones</i>				14. MOTHER'S MAIDEN NAME <i>Seanna S. Spencer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>577-50-3725</i>		INFORMANT <i>Mildred Patterson, Daughter</i>		Address <i>above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia with renal insufficiency</i> DUE TO (b) <i>Congestive heart failure</i> DUE TO (c) <i>Hypertensive cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug. 15, 1959</i> to <i>Nov. 25, 1959</i> , that I last saw the deceased alive on <i>Nov. 25, 1959</i> , and that death occurred at <i>10:58 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Sylvia M. Lim</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>RFD #1, Box 277-M 11-26-59</i>					
PHYSICIAN'S NAME (Type) <i>Sylvia M. Lim</i>		<i>Edgewater, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/28/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Congressional</i>		22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Inc.</i>				ADDRESS <i>Mt. Rainier, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 30 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>William S. Knaus</i>			

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12151

CERTIFICATE OF DEATH

12151



[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]



MADE IN



12134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JACOB First DONALDSON Middle PARR Last		4. DATE OF DEATH Month November Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1906
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Promoter		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob S. Parr		14. MOTHER'S MAIDEN NAME Sarah Delcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Nancy Anne Parr-Annapolis, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral myocardial infarction DUE TO Coronary artery sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yrs. (c) 5 yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from four , 19 55 , to two , 19 59 , that I last saw the deceased alive on Nov 20 , 19 59 , and that death occurred at 11:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral St., DATE SIGNED 11/20/59			
ACTUAL SIGNATURE John L. Hedeman		M.D. 121 Cathedral St.,	
PHYSICIAN'S NAME (Type) John L. Hedeman		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Lickens		ADDRESS 1100 Ave Bldg	
24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Christina L. House	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12135 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12135 CERTIFICATE OF DEATH

12153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN b <u>3 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>518-5th Street</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>518-5th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Perberson</u> Middle <u>Perberson</u> Last		4. DATE OF DEATH <u>11-29</u> Month <u>19</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 5-85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisher MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>74</u> yrs.
13. FATHER'S NAME <u>UNKNOWN</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS-Md.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
16. SOCIAL SECURITY NO. <u>R14-05-2398</u>		14. MOTHER'S MAIDEN NAME <u>JULIA CROWDY</u>	
17. INFORMANT <u>FELIX T. PERBERSON</u>		Address <u>14 CLAY ST ANNAPOLIS MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown Stomach</u> DUE TO (b) <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>11-26-59</u> , to <u>11-29-59</u> , that I last saw the deceased alive on <u>11-28-59</u> , 19 <u>59</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G.T. Allen</u>		DATE SIGNED <u>6-2-59</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		ADDRESS <u>ANNAPOLIS MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANNAPOLIS MECK</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS-MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u>		ADDRESS <u>ANNAPOLIS-MD.</u>	
24a. REC'D BY REGISTRAR <u>DEC 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

13153

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

12-15-35

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. COLOR [REDACTED]		9. RELIGION [REDACTED]		10. EDUCATION [REDACTED]		11. SOCIAL CLASS [REDACTED]		12. PLACE OF DEATH [REDACTED]	
13. DATE OF DEATH [REDACTED]		14. TIME OF DEATH [REDACTED]		15. CAUSE OF DEATH [REDACTED]		16. MANNER OF DEATH [REDACTED]		17. PLACE OF BURIAL [REDACTED]		18. NAME OF BURIAL PLACE [REDACTED]	
19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]		21. SIGNATURE OF PHYSICIAN [REDACTED]		22. SIGNATURE OF CLERK [REDACTED]		23. SIGNATURE OF JUDGE [REDACTED]		24. SIGNATURE OF NOTARY [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]		27. SIGNATURE OF PHYSICIAN [REDACTED]		28. SIGNATURE OF CLERK [REDACTED]		29. SIGNATURE OF JUDGE [REDACTED]		30. SIGNATURE OF NOTARY [REDACTED]	

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1. NAME OF DECEASED
[REDACTED]

2. SEX
[REDACTED]

3. AGE
[REDACTED]

4. DATE OF BIRTH
[REDACTED]

5. PLACE OF BIRTH
[REDACTED]

6. OCCUPATION
[REDACTED]

7. MARITAL STATUS
[REDACTED]

8. COLOR
[REDACTED]

9. RELIGION
[REDACTED]

10. EDUCATION
[REDACTED]

11. SOCIAL CLASS
[REDACTED]

12. PLACE OF DEATH
[REDACTED]

13. DATE OF DEATH
[REDACTED]

14. TIME OF DEATH
[REDACTED]

15. CAUSE OF DEATH
[REDACTED]

16. MANNER OF DEATH
[REDACTED]

17. PLACE OF BURIAL
[REDACTED]

18. NAME OF BURIAL PLACE
[REDACTED]

19. SIGNATURE OF DECEASED
[REDACTED]

20. SIGNATURE OF WITNESS
[REDACTED]

21. SIGNATURE OF PHYSICIAN
[REDACTED]

22. SIGNATURE OF CLERK
[REDACTED]

23. SIGNATURE OF JUDGE
[REDACTED]

24. SIGNATURE OF NOTARY
[REDACTED]

25. SIGNATURE OF DECEASED
[REDACTED]

26. SIGNATURE OF WITNESS
[REDACTED]

27. SIGNATURE OF PHYSICIAN
[REDACTED]

28. SIGNATURE OF CLERK
[REDACTED]

29. SIGNATURE OF JUDGE
[REDACTED]

30. SIGNATURE OF NOTARY
[REDACTED]

12181

CERTIFICATE OF DEATH

12154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> <u>Md.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen-burnie</u>				c. LENGTH OF STAY IN TB <u>9 Mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Convalescent Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen-burnie</u> <u>3 Vol-4</u>			
f. STREET ADDRESS <u>None</u> <u>Balto. 17, Md.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary Clara</u> Middle <u>Powell</u> Last <u></u>				4. DATE OF DEATH <u>Nov. 10, 1959</u> Day <u>10</u> Month <u>Nov.</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1895</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Anacostia Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Delia Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Cherry Powell</u> Address <u>1048 Penna. Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with aortic stenosis.</u> 420.0 DUE TO <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 ? yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adenocarcinoma of thyroid, probable. Chronic brain syndrome.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>January 5, 1959</u> , to <u>November 9, 1959</u> , that I last saw the deceased alive on <u>November 7, 1959</u> , and that death occurred at <u>10:15 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>400 N. Carrollton Ave.</u> DATE SIGNED <u>November 10, 1959</u>							
ACTUAL SIGNATURE <u>James M. Pair</u>				M.D. <u>400 N. Carrollton Ave.</u>			
PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u>				<u>Baltimore 23, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson</u> ADDRESS <u>916 Penna. Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 12 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12182

CERTIFICATE OF DEATH

12155

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>	
c. LENGTH OF STAY IN 1b <u>life time</u>		d. STREET ADDRESS <u>Shady Side</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fredus Edmund Proctor</u>		4. DATE OF DEATH <u>November 23 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/96</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>	
11. BIRTHPLACE (State or foreign country) <u>Shadyside Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Westey Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Ida Virginia Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>Lucy A Proctor Shadyside Md</u>	
17. INFORMANT <u>Lucy A Proctor Shadyside Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of larynx</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1959</u> , to <u>Nov. 23, 1959</u> , that I last saw the deceased alive on <u>Nov. 23, 1959</u> , and that death occurred at <u>1:15 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Side, Md.</u> DATE SIGNED <u>11/24/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON National</u>	22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Chesville Lee</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN	c. LENGTH OF STAY IN lb FEW MINUTES	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORFOLK 83x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 554 ON WAY TO FEGM HOSPITAL		d. STREET ADDRESS USS VULCAN AR 5	
3. NAME OF DECEASED (Type or print) ROBERT First Middle Last QUIGLEY		4. DATE OF DEATH Month NOV Day 1 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1938
9. AGE (in years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Naval dental tech.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lansing, Michigan		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Donald Quigley		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) In US Navy at present		16. SOCIAL SECURITY NO. 376-38-3756	
17. INFORMANT RICHARD JAMES OSTHEIM (FRIEND)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Car ran off road and turned over.			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 1130 p. m. Oct 31 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> Route 554	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) SEVERN A A COUNTY MD.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) GUSTAVE H. FAUBERT		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED 1 Nov 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 11/3/59	
22c. NAME OF CEMETERY OR CREMATORY Lansing		22d. LOCATION (City, town, or county) (State) Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook Sna.</i>		24a. REC'D BY REGISTRAR DATE NOV 3 '59	
ADDRESS Balto.		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12184

CERTIFICATE OF DEATH

Reg. Dist. No.

12157

1. PLACE OF DEATH a. COUNTY Anne ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1mo. 17 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 219 E. Federal Street					
3. NAME OF DECEASED (Type or print) First Richard Middle Last Rice				4. DATE OF DEATH Month 11 Day 11 Year 19 59					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1900			
9. AGE (In years last birthday) yrs. 59		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----					
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown					
17. INFORMANT Hospital Records				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Bronchopneumonia 020.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bulbar Paralysis DUE TO (c) Congenital Syphilis with Gumma of Brain								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			
20f. (City or town) (County) (State) -----				20g. (City or town) (County) (State) -----					
21. I certify that I attended the deceased from 9/24 , 19 59 , to 11/11 , 19 59 , that I last saw the deceased alive on 11/11 , 19 59 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Hildegard Heard Reissman Crownsville State Hospital, Md. 11/12/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M.D. Crownsville State Hospital, Md. 11/12/59									
22a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL				22b. DATE THEREOF 11-16-59		22c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park			
22d. LOCATION (City, town, or county) (State) Arbutus Md.				23. FUNERAL DIRECTOR'S SIGNATURE Milton E. Elickson - 11294 Caroline St.					
24a. REC'D BY REGISTRAR NOV 18 1959				24b. REGISTRAR'S SIGNATURE Arthur S. Knepp					

1874

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THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
JANUARY 1, 1874
SIR,
I have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the matter of the purchase of land for the purpose of establishing a military reservation at the mouth of the River of the same name, in the Territory of New Mexico.
The matter is now under consideration, and I am unable to say whether or not it will be approved.
Very respectfully,
Your obedient servant,
J. M. Smith,
Secretary of the Army.

12136

CERTIFICATE OF DEATH

Reg. Dist. No.

12158

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 EASTERN AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>C.</u> Middle <u>CORNER</u> Last <u>RIDOUT</u>				4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-3-1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u> Hours <u>15</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>CHARLES RIDOUT</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE CORNER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>NINA P. RIDOUT #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTEROSCLEROTIC CORONARY ARTERY DIS.</u> DUE TO (c) <u>10 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month <u>11</u> Day <u>1</u> Year <u>1959</u> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>ANNAPOLIS</u>				20g. (County) <u>ANNE ARUNDEL</u>		20h. (State) <u>M.D.</u>	
21. I certify that I attended the deceased from <u>11-1-1959</u> , to <u>11-1-1959</u> , that I last saw the deceased alive on <u>11-1-1959</u> , and that death occurred at <u>11:56</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>41 Southgate Ave ANNAPOLIS MD</u> DATE SIGNED <u>11/2/59</u>							
ACTUAL SIGNATURE <u>Edward J. Beck</u>				PHYSICIAN'S NAME (Type) <u>ANNAPOLIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. MARGARETS</u>		22d. LOCATION (City, town, or county) (State) <u>St. MARGARETS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Gifford</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12160

Reg. Dist. No.

12186

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Geo G. Meade</u>		c. LENGTH OF STAY IN 1b <u>30 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> <u>1614-2</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bldg. 9800 Savage Road NSA Oper. Bldg.</u>				d. STREET ADDRESS <u>4709 Blackfoot Road</u>			
3. NAME OF DECEASED (Type or print) First <u>BENJAMIN</u> Middle <u>D.</u> Last <u>SCHULTZ</u>				4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4 1894</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S Government</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Schultz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>106-09-8811</u>		17. INFORMANT <u>Mr. James C. Stanier</u>		Address <u>NSA Oper. Bldg.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4-20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert MD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>GUSTAVE H. FAUBERT, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10 Nov 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville Maryland.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12137

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12161

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY B ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND	
c. LENGTH OF STAY IN 1b 1 1/2 hrs.		d. STREET ADDRESS 19 Goodrich Rd.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle SCHURR Last		4. DATE OF DEATH Month 11 Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-59
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas Paul SCHURR		14. MOTHER'S MAIDEN NAME Vilma D'AVI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) T.P. SCHURR, 19 Goodrich Rd.,		Address Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 560.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		DIAPHRAGMATIC HERNIA INTERVAL BETWEEN ONSET AND DEATH 1 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO AUTOPSY DONE—SURGERY WAS PERFORMED	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11:13 , 19 59 , to 2330 11-13 1959 , that I last saw the deceased alive on 11-13 , 19 59 , and that death occurred at 2330 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND DATE SIGNED 7. M. KENNY			
ACTUAL SIGNATURE F. M. KENNY		PHYSICIAN'S NAME (Type) F. M. KENNY LT MC USNR	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-59	
22c. NAME OF CEMETERY OR CREMATORY Naval Academy		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sr		24a. REC'D BY REGISTRAR NOV 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraso			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

2137

18191

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1874		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. DECEASED AT Home		12. PLACE OF DEATH Home		13. DATE OF DEATH 1940		14. TIME OF DEATH 10:00 AM		15. CAUSE OF DEATH Heart Disease	
16. DISEASE OR INJURY Heart Disease		17. PERIOD OF ILLNESS Several weeks		18. PREVIOUS ILLNESS None		19. MEDICAL ATTENTION Physician		20. BURIAL Buried	
21. SIGNATURE OF DECEASED James H. Harris		22. SIGNATURE OF WITNESS John Doe		23. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Harris		24. SIGNATURE OF PHYSICIAN Dr. Smith		25. SIGNATURE OF REGISTRAR John Doe	
26. PLACE OF INTERMENT Cemetery		27. DATE OF INTERMENT 1940		28. TIME OF INTERMENT 10:00 AM		29. NAME OF INTERMENT SOCIETY None		30. NAME OF MINISTER None	
31. NAME OF REGISTRAR John Doe		32. ADDRESS OF REGISTRAR 123 Main St.		33. CITY Baltimore		34. STATE Maryland		35. COUNTY Baltimore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12138
CERTIFICATE OF DEATH

12162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Linthicum Heights	
f. STREET ADDRESS 234 Hammonds Ferry Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stephan UNNAMED Dale First Middle Last		4. DATE OF DEATH Month November Day 20 Year 1959	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 19, 1959	
9. AGE (In years lost birthday) yrs. 20		10. IF UNDER 1 YEAR Months 20 Days 58	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U.S.	
15. FATHER'S NAME Roger Edward SCHUTTENHELM		16. MOTHER'S MAIDEN NAME Jane Sophie KRAUS	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. Hospital Records	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Prematurity		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 19 , 19 59 , to Nov 20 , 19 59 , that I last saw the deceased alive on Nov 19 , 19 59 , and that death occurred at 6:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 95 Cathedral St., Annapolis, Md. DATE SIGNED 11/20/59			
ACTUAL SIGNATURE Neil H. Sims		PHYSICIAN'S NAME (Type) Neil H. SIMS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-59	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

2063502XVI

12102

CERTIFICATE OF DEATH

12138

Name of Deceased

Age

Sex

Place of Birth

Date

Time

Cause of Death

Place of Death

Sex

Age

Place of Birth

Sex

Age

Date

Time

U.S.

State

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

Place of Death

12187

CERTIFICATE OF DEATH

12163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY H.A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MARGARETS				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REVELL HIGHWAY				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. MARGARETS			
f. STREET ADDRESS REVELL HIGHWAY				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY MAUDE Minnick Scott				4. DATE OF DEATH 11 26 1959			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-19-1881	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE R. MINNICK				14. MOTHER'S MARDEN NAME PATRICIA STALER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT J. CARROLL SCOTT				Address # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Cardiac Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Arterial Hypertension many yrs. DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 9th , 19 59 , to Nov 26 , 19 59 , that I last saw the deceased alive on Nov 26 , 19 59 , and that death occurred at 4 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Oliver Purvis M.D.				ADDRESS (Street, city or town, state) 40 Franklin St., Annapolis, Md.			
DATE SIGNED 11/27/59				PHYSICIAN'S NAME (Type) J. OLIVER PURVIS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-29-59		22c. NAME OF CEMETERY OR CREMATORY ST. MARGARETS		22d. LOCATION (City, town, or county) (State) ST. MARGARETS Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. ...				24a. REC'D BY REGISTRAR — DATE DEC 1 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. ...				24c. REGISTRAR'S SIGNATURE —			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1981

12139

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 99 Cathedral St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mary		First Mary Middle C Last SELLERS		4. DATE OF DEATH Month November Day 25 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 8, 1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME J. M. Dugan				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Howard Sellers		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADRENAL INSUFFICIENCY 260X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) CELLULITIS OF BUTTOCKS DUE TO (c) DIABETES MELLITUS							INTERVAL BETWEEN ONSET AND DEATH 48 HOURS 7 DAYS 10 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE RHEUMATOID ARTHRITIS; ACUTE GASTRO-ENTERITIS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 22, 1959 , to Nov. 24, 1959 , that I last saw the deceased alive on Nov. 24, 1959 , and that death occurred at 5:05A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck		M.D.		ADDRESS (Street, city or town, state) 41 Southgate Ave.,		DATE SIGNED 11/25/59	
PHYSICIAN'S NAME (Type) Edward S. Beck		Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-28-59		22c. NAME OF CEMETERY OR CREMATORY Floral Park		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Layton Sons				ADDRESS Annapolis Md.		24a. REC'D BY REGISTRAR DATE NOV 27 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12104

STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1913



John Arundel

Unemployed

Annapolis

John Arundel, married, white, male

39 years old

November 2, 1913

November 2, 1913

Indiana

Female

Housewife

Housewife

Housewife

Housewife

1913
1913
1913

Housewife
Housewife
Housewife

Housewife

Nov. 22, 1913

Nov. 22, 1913

11:22:52

4:00:00 AM

Annapolis, Md.

Edward S. Beck

John Arundel, married, white, male
Housewife
Housewife
Housewife

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12165

12188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.				c. LENGTH OF STAY IN 1b 29 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Children's Center District Training School Laurel, Md.				d. STREET ADDRESS 923 Shepherd Street N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle J. Last Sexton				4. DATE OF DEATH Month November Day 17 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10, 1899	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 17 Days 19 Hours 59		IF UNDER 24 HRS. Hours 17 Min. 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institution				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North Dakota	
13. FATHER'S NAME Edward J. Sexton				14. MOTHER'S MAIDEN NAME Margaret			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. --		17. INFORMANT Children's Center, Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1 week DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Bronchial asthma, hypogonadism, neuritis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from August, 1956 to Nov. 17, 1959 , that I last saw the deceased alive on 7:50 A.M., 1959 , and that death occurred at 7:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 11/18/59							
ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D.				PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D. Children's Center, Laurel, Md. 11/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11/19/59		22c. NAME OF CEMETERY OR CREMATORY DTS Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hane, Jr. Supt DTS Laurel, Md.				24a. REC'D BY REGISTRAR NOV 25 '59		24b. REGISTRAR'S SIGNATURE Orlando S. Hane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12166

12140

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 4mo. 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn d. STREET ADDRESS Route 2, Box 195 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward First Middle Last Smith		4. DATE OF DEATH Month Day Year 11 18 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1901
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tom Smith		14. MOTHER'S MAIDEN NAME Ella	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-09-8984	
17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 260X DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Diabetes Mellitus (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Metabolism Disease INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. -- -- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/17 , 19 59 , to 11/18 , 19 59 , that I last saw the deceased alive on 11/18 , 19 59 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Hildegard Heard Reissman M.D. Crownsville State Hospital, Md. 11/19/59 PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 11/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1959	
22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Pk.		22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Hanna ADDRESS 1631 David Hill Ave.		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12189

CERTIFICATE OF DEATH

12167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Lewis First H. Middle Smith Last				4. DATE OF DEATH Nov. Month 23 Day 1959 Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28. 1885	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret				10b. KIND OF BUSINESS OR INDUSTRY Printer		11. BIRTHPLACE (State or foreign country) Miss.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Edwaed H. Smith				14. MOTHER'S MAIDEN NAME Mary. Dilly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Richard. Smith Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) Several years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 30, 1959 to Oct. 28, 1959 , that I last saw the deceased alive on Nov. 23, 1959 , and that death occurred at 5:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sylvia M. Lim				ADDRESS (Street, city or town, state) RED # 1, Box 277-M, Edgewater, Md.			
PHYSICIAN'S NAME (Type) Sylvia M. Lim				DATE SIGNED 11-23-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11.25.59		22c. NAME OF CEMETERY OR CREMATORY Fort. Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral Home				ADDRESS 300.4th st N E.		24a. REC'D BY REGISTRAR DATE NOV 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma							

CERTIFICATE OF DEATH

12184

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CERTIFICATE OF DEATH

12168

Reg. Dist. No.

12190

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 month		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. STREET ADDRESS ?									
3. NAME OF DECEASED (Type or print) First Millie		Middle Elizabeth		Last Smith		4. DATE OF DEATH Month 11		Day 9		Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877, Mar 2nd		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 2		IF UNDER 24 HRS. Days 2		Hours 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Room House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Crown House		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Daniel Smith				14. MOTHER'S MAIDEN NAME Caroline Hawthorn							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 136-26-5532A		INFORMANT Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Arteriosclerotic Cardiovascular Disease DUE TO (c) Generalized and Cerebral Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to Arteriosclerosis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----									
20c. TIME OF INJURY Month, Day, Year Hour a. m. - p. m. - - - 19 - - -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - -		20f. (City or town) - - - - -		(County) - - - - -		(State) - - - - -	
21. I certify that I attended the deceased from 10/9 19 59 , to 11/9 19 59 , that I last saw the deceased alive on 11/9 19 59 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville State Hospital, Md. 11/9/59 PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 11/9/59											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/1959		22c. NAME OF CEMETERY OR CREMATORY Union Methodist		22d. LOCATION (City, town, or county) Alexandria Maryland		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barron				ADDRESS Chorleene road		24a. REC'D BY REGISTRAR DATE NOV 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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Page 4

VS A15 (4)
15M 9/58

TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
12141					CERTIFICATE OF DEATH					12169									
										Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1</u> <u>33 West Street</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>33 West Street</u>					d. STREET ADDRESS <u>33 West Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>WITASKI</u> Middle <u>V</u> Last <u>SNYDER</u>					4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>17</u> Year <u>19 59</u>														
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>? ? , 1880</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>		IF UNDER 24 HRS. Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>					11. BIRTHPLACE (State or foreign country) <u>Poland</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>none</u>					INFORMANT <u>Morris Snyder- Son- Same as # 2</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arterio Sclerotic Heart Disease</u> (c) <u>6 months</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>					20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>March 1, 1959</u> , to <u>11/16/1959</u> , that I last saw the deceased alive on <u>11-16-1959</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 Shaw Street Annapolis, Maryland</u> DATE SIGNED <u>November 17, 1959</u>																			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.					PHYSICIAN'S NAME (Type) <u>James R. Martin MD</u> <u>6 Shaw Street Annapolis, Maryland</u>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Nov. 18, 1959</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel Cemetery</u>					22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>					ADDRESS <u>Annapolis, Maryland</u>					24a. REC'D BY REGISTRAR <u>NOV 20 '59</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>				

1. *Introduction*

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12191

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>		c. LENGTH OF STAY IN lb <u>3 YEAR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 HARMONY AVE</u>				d. STREET ADDRESS <u>10 HARMONY</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH TIFFANY TARR</u>				4. DATE OF DEATH Month Day Year <u>NOV. 27 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 8, 1903</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry William Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-5303</u>		INFORMANT <u>MR GEORGE L. TARR</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hypertensive cardio-vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>6 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 1959, to <u>NOV</u> , 1959, that I last saw the deceased alive on <u>27 Nov</u> , 1959, and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>715 COTTER Rd GLEN BURNIE, Md</u> <u>28 Nov '59</u> ACTUAL SIGNATURE <u>Gene D. Trettin</u> PHYSICIAN'S NAME (Type) <u>GENE D. TRETTIN</u> <u>715 COTTER Rd. GLEN BURNIE, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER & SONS INC. BALTIMORE MD</u>				24. REC'D BY REGISTRAR DATE <u>DEC 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

15150

UNITED STATES DEPARTMENT OF AGRICULTURE

TECHNICAL BUREAU

15151



[Faint, illegible text, likely bleed-through from the reverse side of the page.]

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12171 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2090 Forest Drive		d. STREET ADDRESS Apt. 6, Carver Street	
3. NAME OF DECEASED (Type or print) LOTIE		4. DATE OF DEATH Month November Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Samuel Jones		14. MOTHER'S MAIDEN NAME Queenie Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-073337	
17. INFORMANT Lena Jones Mayo Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of right temple DUE TO (b) 976 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Partial	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Shot self in head	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head		20c. TIME OF INJURY Month, Day, Year 8:15 a.m. 11/13 1959	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Annapolis		(County) Anne Arundel	
(State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
22a. ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		22b. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22c. EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		22d. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22e. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22f. DATE SIGNED 11/13/59	
22g. ADDRESS (Street, city, town, or county) 108 Wash. St. Annapolis Md.		22h. REC'D BY REGISTRAR Arthur & Kline	
22i. REGISTRAR'S SIGNATURE William Reese		22j. DATE NOV 17 '59	

SALS:

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12143

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 518 2nd St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lawrence		First R. Middle TUERS Last		4. DATE OF DEATH Month November Day 25 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1898		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Academy		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Arthur M. Luers		14. MOTHER'S MAIDEN NAME Emma M. Putter					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (I)		16. SOCIAL SECURITY NO. —		INFORMANT Viola A. Luers		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS MYOCARDIAL INFARCTION DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) ARTERIOSCLEROTIC CORONARY/ART. DISEASE DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS; ESOPHAGEAL VARICES; HEMATURIA, CAUSE UNKNOWN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 20, 1959 , to Nov. 25, 1959 , that I last saw the deceased alive on Nov. 25, 1959 , and that death occurred at 10:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 41 Southgate Ave., Annapolis, Md. DATE SIGNED 11/25/59							
ACTUAL SIGNATURE Edward S. Beck		M.D. 41 Southgate Ave., Annapolis, Md.					
PHYSICIAN'S NAME (Type) Edward S. Beck		Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 28-59		22c. NAME OF CEMETERY OR CREMATORY Belcrest Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		ADDRESS Annapolis Md		24. REC'D BY REGISTRAR DEC 1 59		25. REGISTRAR'S SIGNATURE Arthur S. Trawa	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

16173

15123



Handwritten notes and signatures, including a large signature that appears to be "John D. ...".

Handwritten notes and signatures, including a large signature that appears to be "John D. ...".

Handwritten notes and signatures, including a large signature that appears to be "John D. ...".

CERTIFICATE OF DEATH

Reg. Dist. No.

12173

12144

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 9 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A. A. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mark Middle Allen Last VANSCOY		4. DATE OF DEATH Month November Day 1 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 31, 1959
9. AGE (In years lost birthday) yrs. 9		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Perry Edward VANSCOY		14. MOTHER'S MAIDEN NAME Peggy Marie HOAGLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 31, 19 59 , to Nov. 1, 19 59 , that I last saw the deceased alive on Nov. 1, 19 59 , and that death occurred at 3:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edith Rodler		ADDRESS (Street, city or town, state) 45 Franklin St., DATE SIGNED 11/2/59	
PHYSICIAN'S NAME (Type) Edith Rodler		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-2-59	
22c. NAME OF CEMETERY OR CREMATORY HILLCREST		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor		24a. REC'D BY REGISTRAR NOV 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the law.

VS A15 (4)
15M 9/58

2263553XVI

CERTIFICATE OF DEATH

1914

1914

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

STATE OF MARYLAND—BALTIMORE, 18

Item 6 Film G253 12/3/59 iwk

12146

CERTIFICATE OF DEATH

Reg. Dist. No.

12175

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospital</u>				d. STREET ADDRESS <u>36 N. GLEN AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THELMA</u> Middle <u>WESTERVELT</u> Last <u>WESTERVELT</u>				4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>1 MV white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-10-1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>TROY N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>EUGENE H YATT</u>				14. MOTHER'S MAIDEN NAME <u>ANNA VAN KIRK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>HENRY WESTERVELT</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenal Cortical Failure</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Colon (operated)</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>26 HOURS</u> <u>6 WKS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>57</u> , to <u>22 NOV</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>22 NOV</u> , 19 <u>59</u> , and that death occurred at <u>3:40 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward A Beck</u>				ADDRESS (Street, city or town, state) <u>4 Southgate Ave</u> DATE SIGNED <u>4/27/59</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN MEM.</u>		22d. LOCATION (City, town, or county) (State) <u>GLEN BURNIE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Son Annapolis Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

CERTIFICATE OF DEATH

2152

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1918	
AGE		SEX	
65		M	
RACE		RELIGION	
W		M	
BIRTH PLACE		PLACE OF BIRTH	
MD		MD	
MARRIED		DATE OF MARRIAGE	
Y		JAN 15 1853	
EDUCATION		OCCUPATION	
H		FARMER	
PREVIOUS ILLNESS		CAUSE OF DEATH	
NONE		HEART DISEASE	
DATE OF LAST ILLNESS		PLACE OF DEATH	
JAN 10 1918		HOME	
NAME OF PHYSICIAN		NAME OF BURIAL PLACE	
J. H. HARRIS		CATHOLIC CHURCH	
DATE OF INTERMENT		NAME OF INTERMENT PLACE	
JAN 16 1918		CATHOLIC CHURCH	
NAME OF FUNERAL HOME		NAME OF MINISTER	
J. H. HARRIS		J. H. HARRIS	
DATE OF FUNERAL		NAME OF CHURCH	
JAN 16 1918		CATHOLIC CHURCH	
NAME OF CEMETERY		NAME OF GRAVE	
CATHOLIC CHURCH		CATHOLIC CHURCH	

7

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12192

CERTIFICATE OF DEATH

Reg. Dist. No.

12176

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b lmo. 7 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mary Middle Wilson Last Wilson		4. DATE OF DEATH Month 11 Day 17 Year 1959		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 11 Days 17 Hours 19 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----		
11. BIRTHPLACE (State or foreign country) Unknown Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown Thomas Hawkins		14. MOTHER'S MAIDEN NAME Unknown Mary Hawkins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		
INFORMANT Medical Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Heart Failure DUE TO Arteriosclerotic Cardiovascular Disease with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Aneurysm of Arteriosclerotic Origin DUE TO (c) -----				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----		
21. I certify that I attended the deceased from 10/10 , 19 59 , to 11/17 , 19 59 , that I last saw the deceased alive on 11/17 , 19 59 , and that death occurred at 12:10 A.M. , from the causes and on the date stated above.				
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville State Hospital, Md. DATE SIGNED 11/17/59		
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		Crownsville State Hospital, Md. 11/17/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11-20-59		22b. DATE THEREOF		
22c. NAME OF CEMETERY OR CREMATORY Bruce Hill		22d. LOCATION (City, town, or county) (State) Annapolis Md		
23. FUNERAL DIRECTOR'S SIGNATURE John Reese (ii)		ADDRESS 108 W Washington St		
24a. REC'D BY REGISTRAR NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

12132

CERTIFICATE OF DEATH

12132

NAME: HINDLEY

DATE OF BIRTH: 1901

CHOWNSVILLE STATE HOSPITAL

1901

Medical Records

CHOWNSVILLE STATE HOSPITAL

CHOWNSVILLE STATE HOSPITAL

CHOWNSVILLE STATE HOSPITAL

12193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 14 years 8mo. 9 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marlboro		d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gus Middle Young Last Young		4. DATE OF DEATH Month 11 Day 21 Year 1959		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1889?		9. AGE (In years last birthday) 70? yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure Secondary to Syphilis DUE TO Myocardial Infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarct (c) Myocardial Infarct		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis - Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ***		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ***		20c. TIME OF INJURY Month, Day, Year Hour a. m. - - - - - p. m. - - - - - 19		20d. INJURY OCCURRED While - - - - - at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 19		20f. (City or town) 19		20g. (County) 19	
20h. (State) 19		21. I certify that I attended the deceased from 3/12 , 19 45 , to 11/21 , 19 59 , that I last saw the deceased alive on 11/21 , 19 59 , and that death occurred at 11:10P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 11/23/59		22a. REC'D BY REGISTRAR DATE NOV 27 '59		22b. REGISTRAR'S SIGNATURE William S. Heard		22c. NAME OF CEMETERY OR CREMATORY University of Maryland		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. K. Reissman		23a. ADDRESS 108 W. 1st St. Baltimore, Md.		23b. DATE THEREOF 11/23/59		23c. NAME OF CEMETERY OR CREMATORY University of Maryland		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12193

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

12193

NAME OF DECEASED		DATE OF DEATH	
JAMES A. [illegible]		[illegible]	
PLACE OF DEATH		CAUSE OF DEATH	
[illegible]		[illegible]	
AGE		SEX	
[illegible]		[illegible]	
DATE OF BIRTH		PLACE OF BIRTH	
[illegible]		[illegible]	
OCCUPATION		MARRIAGE	
[illegible]		[illegible]	
EDUCATION		RELIGION	
[illegible]		[illegible]	
PREVIOUS ILLNESS		TREATMENT	
[illegible]		[illegible]	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
[illegible]		[illegible]	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[illegible]		[illegible]	
DATE OF SIGNATURE		PLACE OF SIGNATURE	
[illegible]		[illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12147

CERTIFICATE OF DEATH

12178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle YOUNG Last YOUNG				4. DATE OF DEATH Month November Day 11 Year 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 11, 1972	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min.	IF UNDER 24 HRS. Months 87 Days 87 Hours 87 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Building				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Edward Young				14. MOTHER'S MAIDEN NAME Eliza - Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. UNKNOWN			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Internal Aortic Rupture DUE TO Cardiovascular Disease Grade III Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Myocardial Infarction (c) Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 10, 1959 , to Nov. 11, 1959 , that I last saw the deceased alive on Nov. 10, 1959 , and that death occurred at 12:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. L. Richardson				M.D. 110 Clay St., DATE SIGNED 11/11/59			
PHYSICIAN'S NAME (Type) R. L. Richardson				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-14-59		22c. NAME OF CEMETERY OR CREMATORY Brewer - Hill		22d. LOCATION (City, town, or county) (State) Annapolis - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks				24a. REC'D BY REGISTRAR NOV 13 '59			
ADDRESS Annapolis - Md.				24b. REGISTRAR'S SIGNATURE Carlton & Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12147

CERTIFICATE OF DEATH

12147

1. Name of deceased *James M. Smith*
2. Sex *Male*
3. Age *45*
4. Date of death *October 12, 1914*
5. Place of death *Home*
6. Cause of death *Heart disease*
7. Signature of physician *J. H. Jones*
8. Signature of registrar *W. B. Brown*
9. Date of registration *October 15, 1914*

James M. Smith
Heart disease
October 12, 1914
Home
J. H. Jones
W. B. Brown
October 15, 1914

James M. Smith
Heart disease
October 12, 1914
Home
J. H. Jones
W. B. Brown
October 15, 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12194

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12179

Reg. Dist. No. 23

1. PLACE OF DEATH o. COUNTY <u>312 Broadway Blvd Glen Burnie</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Q. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Md</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie Md.</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>312 Broadway Blvd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Geltman</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19, 1871</u>
9. AGE (In years last birthday) <u>87 yrs.</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm. (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Honore Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jack Louis - Geltman -</u>		14. MOTHER'S MAIDEN NAME <u>Lena - Weind -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO/E</u>	
17. INFORMANT <u>Mrs. Adora Lawrence</u>		Address <u>312 Broadway Blvd Glen Burnie</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) <u>Cerebro. Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1, 1959</u> , to <u>Nov 8, 1959</u> , that I last saw the deceased alive on <u>Nov 9, 1959</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Bellinger</u> M.D.		ADDRESS (Street, city or town, state) <u>10 P Center on Glen Burnie Md</u>	
DATE SIGNED <u>Nov 9, 1959</u>			
PHYSICIAN'S NAME (Type) <u>James S. Bellinger M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST JOHNS LUTHERAN</u>		22d. LOCATION (City, town, or county) (State) <u>PEEFLEERS CORNER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. HIGGINBOTHOM</u>		ADDRESS <u>ELICOTT CITY MD</u>	
24a. REC'D BY REGISTRAR <u>DATE NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Thoma</u>	

12194

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

12194

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/1/29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Author		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. DATE OF DEATH 4/4/68		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH FBI Building, Baltimore, MD		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF NEXT OF KIN None		18. SIGNATURE OF PHYSICIAN J. Edgar Hoover		19. SIGNATURE OF CORONER J. Edgar Hoover		20. SIGNATURE OF JURY None	
21. SIGNATURE OF REGISTRAR J. Edgar Hoover		22. SIGNATURE OF CLERK J. Edgar Hoover		23. SIGNATURE OF WITNESS J. Edgar Hoover		24. SIGNATURE OF JURY None		25. SIGNATURE OF JURY None	